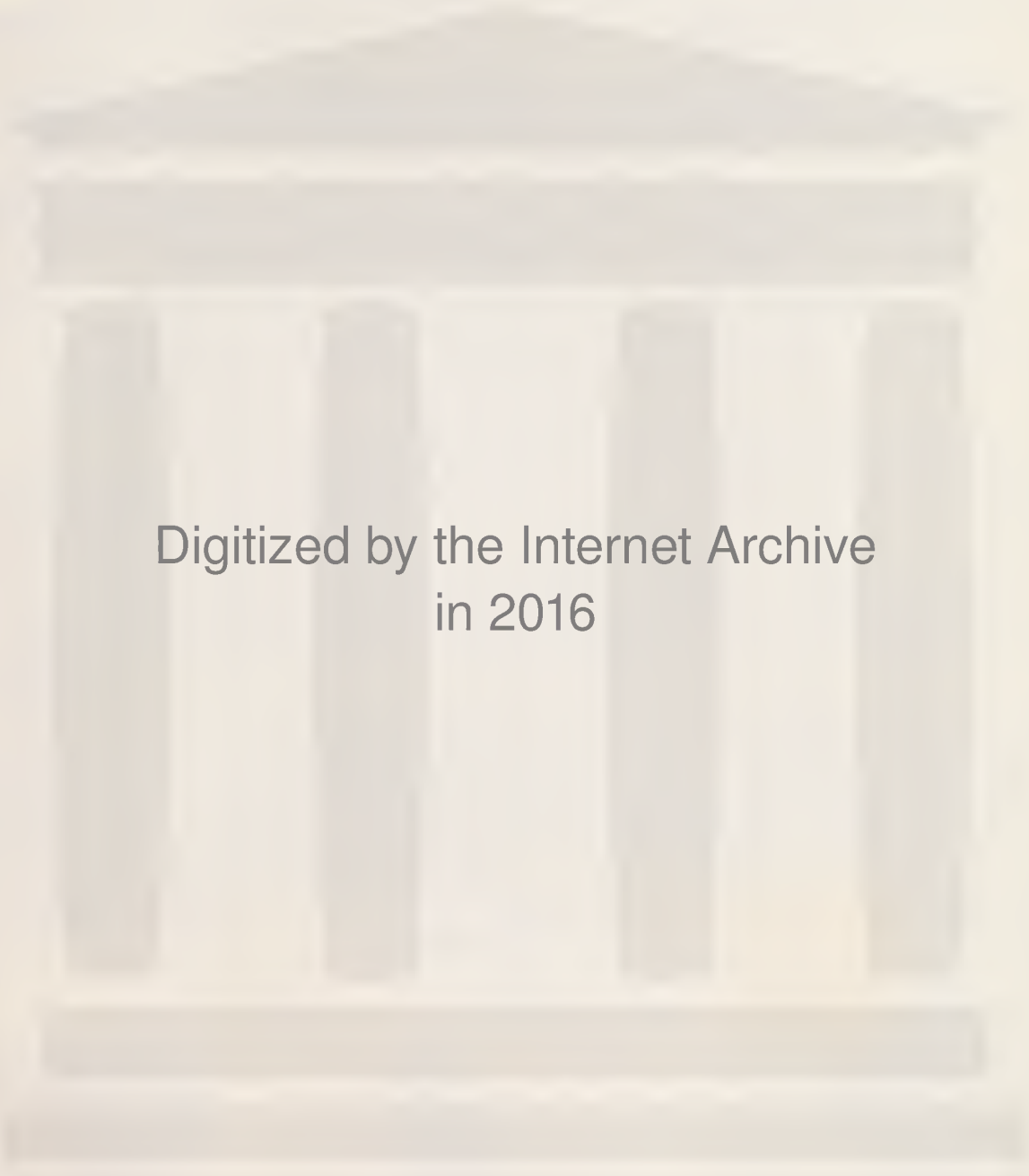

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JOURNAL
of the medical association of
georgia
JANUARY / 1978

journal

Georgians Testify Against NHI

"Don't think that by cooperating with government planners...you can introduce a universal health insurance scheme that will work. The fault is not in the implementation of the concept; it is in the concept itself."

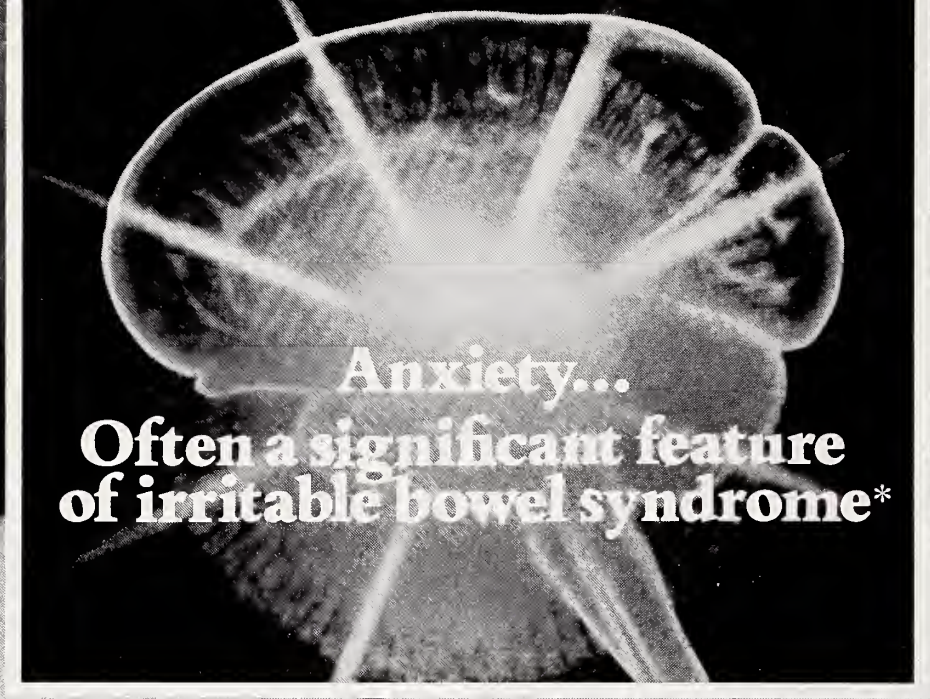
"A compulsory program is inconsistent with ideals of individual freedom."

"It is difficult to overlook that Lenin stated that socialized medicine is the keystone to a socialized nation."

"The American people do not desire more federal control and increased taxes to support programs directed at undermining individualism of spirit or effort."

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Librax is unique among GI medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

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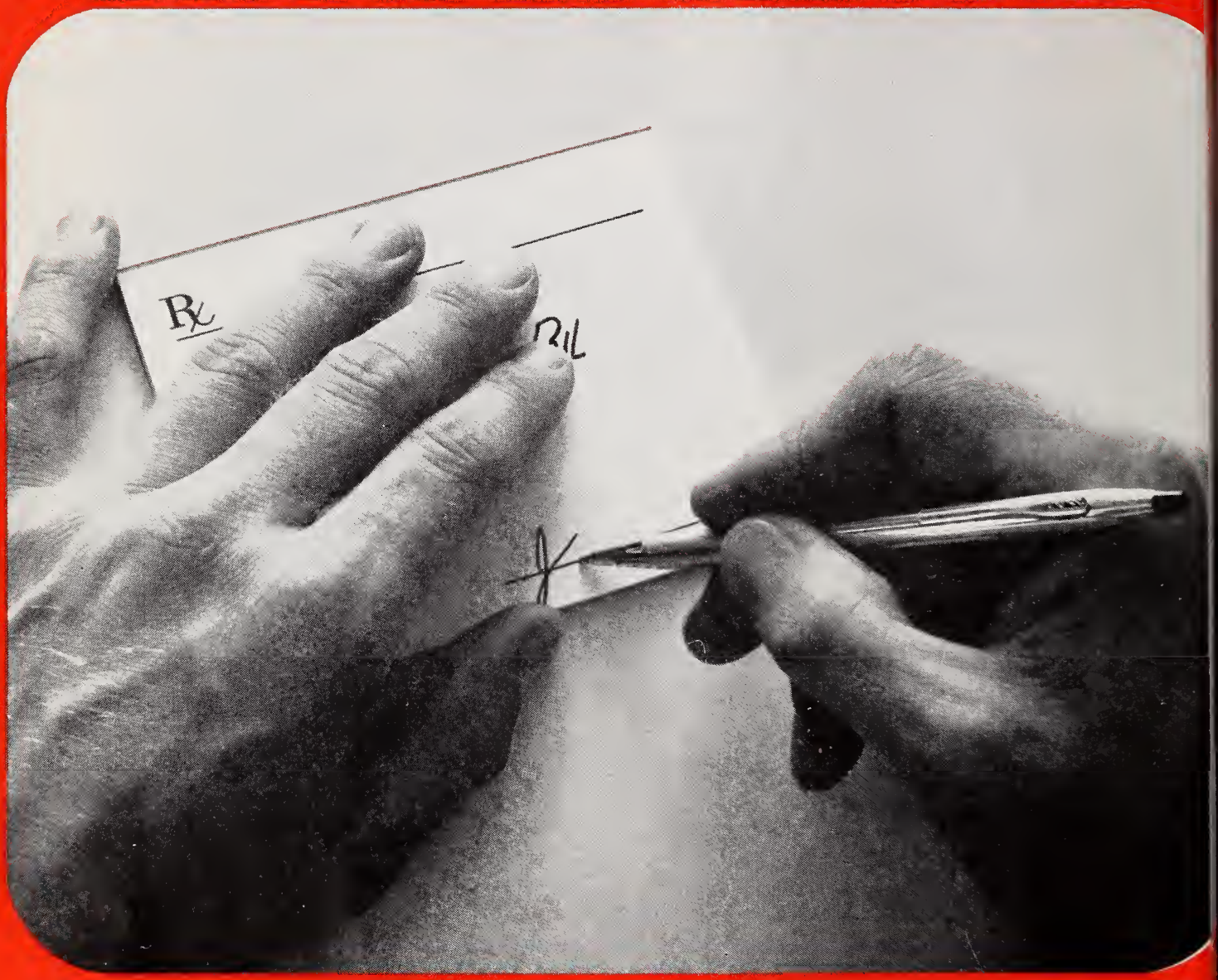
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COVER

Recently, Georgians testified before HEW hearings on national health insurance. Quotes from a few of these are featured on this month's cover. Additional quotes, along with summaries of some of the testimonies, begin on page 33.

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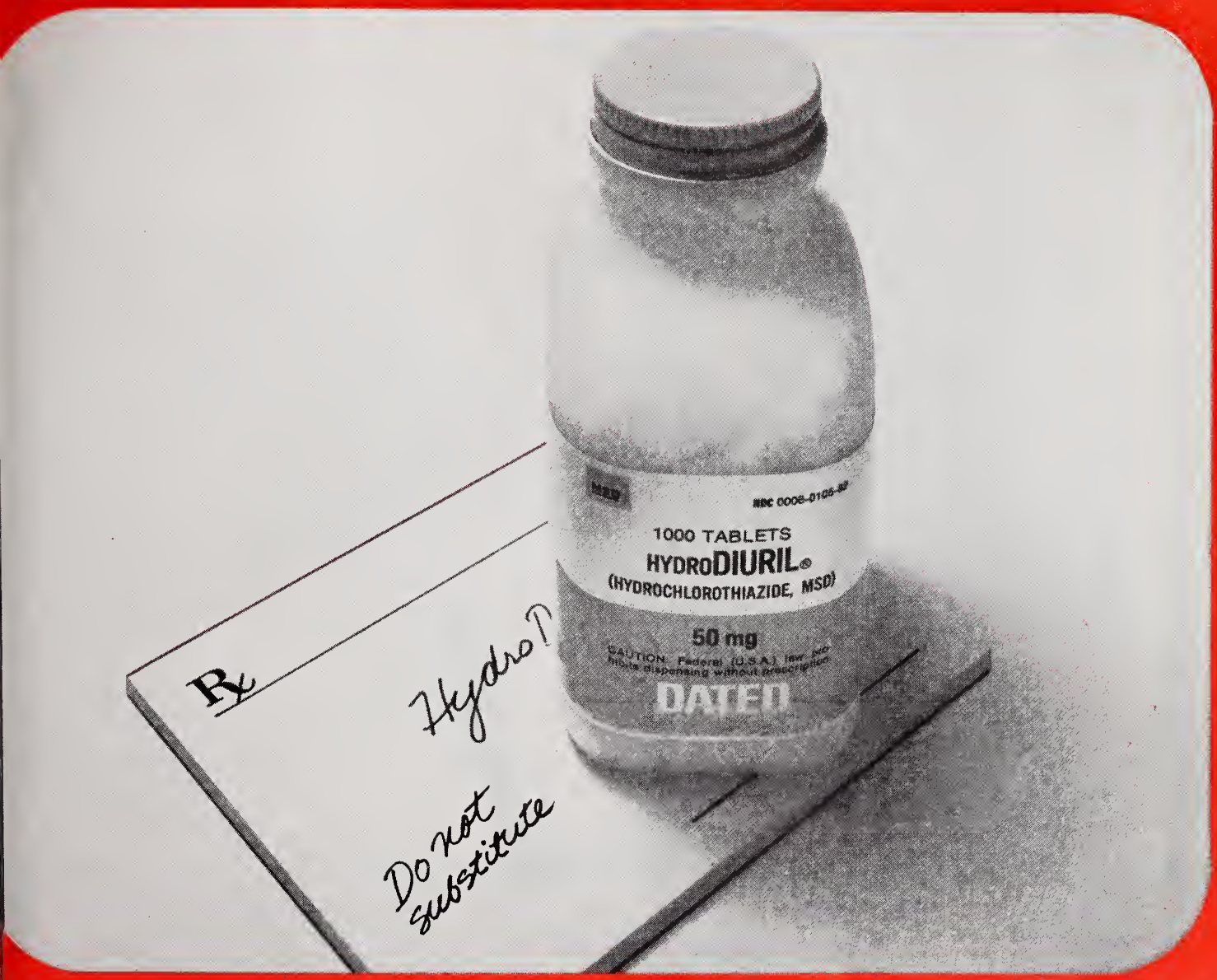
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Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as naus and vomiting. Hypokalemia may develop, especially with brisk diures in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize o exaggerate response of heart to toxic effects of digitalis (e.g., increas ventricular irritability). Hypokalemia may be avoided or treated by us of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not requir specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certai patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

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irment becomes evident, consider withholding or discontinuing iuretic therapy. Thiazides may decrease serum PBI levels without ins of thyroid disturbance. Calcium excretion is decreased by azides. Pathologic changes in the parathyroid gland with hyper- lcemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

lverse Reactions: *Gastrointestinal System*—Anorexia; gastric ir- tion; nausea; vomiting; cramping; diarrhea; constipation; jaundice trahepatic cholestatic jaundice); pancreatitis; sialadenitis. *ntral Nervous System*—Dizziness; vertigo; paresthesias; headache; nthopsia. *matologic*—Leukopenia; agranulocytosis; thrombocytopenia; astic anemia. *rdiovascular*—Orthostatic hypotension (may be aggravated by ohol, barbiturates, or narcotics). *oersensitivity*—Purpura; photosensitivity; rash; urticaria; necrotizing giitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress luding pneumonitis; anaphylactic reactions. *ner*—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; akness; restlessness; transient blurred vision. henever adverse reactions are moderate or severe, thiazide dosage ould be reduced or therapy withdrawn.

te: When used with other antihypertensive drugs, careful observa- ns for changes in blood pressure must be made, especially during ial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

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Medical Meeting Calendar

FEBRUARY

8-9—*Atlanta;* **SECOND ANNUAL SYMPOSIUM ON PERINATAL DISEASE;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30303.

9-10—*Atlanta;* **MOBILITY ASSISTIVE DEVICES;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Bonnie Blossom, RPT, Emory University School of Medicine, Atlanta 30322.

9-10—*Augusta;* **CLINICAL PSYCHIATRY;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

13-17—*Savannah;* **CARDIOLOGY FOR THE CLINICIAN;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Division of Continuing Education, Medical College of Georgia, Augusta 30901.

16-19—*Atlanta;* **GEORGIA PSYCHIATRIC ASSOCIATION ANNUAL SPRING SCIENTIFIC MEETING;** Category 1 Credit; Contact: Harold L. McPheeters, M.D., 130 Sixth St., N.W., Atlanta 30313.

19-22—*New Orleans;* **46th ANNUAL ASSEMBLY OF THE SOUTHEASTERN SURGICAL CONGRESS;** Contact: Anne Glade, The Southeastern Surgical Congress, 315 Boulevard, N.E., Suite 500, Atlanta 30312.

23-25—*Atlanta;* **AN UPDATE IN THE CURRENT CONCEPTS IN HAND MANAGEMENT;** Category 1 Credit; Contact: Lamar L. Fleming, M.D., Luis O. Vasconez, M.D., Michael Brown, OTR, Emory University School of Medicine, Atlanta 30322.

24—*Savannah;* **DAY OF CANCER;** Contact: American Cancer Society, Chatham County Unit, P.O. Box 14356, Savannah 31406.

27-Mar. 1—*Augusta;* **PULMONARY DISEASES;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

MARCH

1-3—*Atlanta;* **SEXUAL COUNSELING OF ADULTS WITH DISEASE OR DISABILITY;** Category 1 Credit; Contact: J. Robin deAndrade, M.D., Emory University School of Medicine, Atlanta 30322.

2-3—*Pine Mountain;* **PULMONARY SYMPOSIUM V (sponsored by W. Central Branch, Georgia Lung Assoc.);** Category 1 Credit; Contact: Philip Brewer, M.D., The Medical Center, Columbus.

5-8—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Wynnell S. Hopkins, Exec. Secretary, Atlanta Graduate Medical Assembly, 875 West Peachtree St., N.E., Atlanta 30309, PH: 881-6128.

7-10—*Durango, Colorado;* **EMERGENCY MEDICINE;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/282-3967.

7-11—*Atlanta;* **67TH ANNUAL MEETING OF THE INTERNATIONAL ACADEMY OF PATHOLOGY, U.S.—CANADIAN DIVISION;** Contact: Leland D. Stoddard, M.D., Department of Pathology, Medical College of Georgia, Augusta 30902.

23-25—*Gainesville, Fla.;* **9TH ANNUAL TOPICS ON INTERNAL MEDICINE; U. OF FLA. COLLEGE OF MEDICINE;** Contact: Bill Rockwood, Coordinator, Division of CME, U. of Fla. Box J-233, J. H. Miller Health Center, Gainesville, Fla. 32610.

27-30—*Atlanta;* **INDEPENDENCE WITH DIGNITY: AGING AND BLINDNESS; AMERICAN FOUNDATION FOR THE BLIND;** Contact: Ms. D. Demby, 15 W. 16th St., N.Y. 10011.

29-30—*Atlanta;* **AMERICAN SOCIETY FOR CLINICAL PHARMACOLOGY & THERAPEUTICS;** Contact: Mrs. E. Galasso, 1718 Gallaher Rd., Norristown, Pa. 19401.

29-Apr. 1—*Atlanta;* **PERSPECTIVES IN SURGERY: LIVER, BILIARY TRACT AND PANCREAS;** Category 1 Credit; Contact: W. Dean Warren, M.D., Garland D. Perdue, M.D., Emory University School of Medicine, Atlanta 30322.

30-31—*Atlanta;* **THE TREATMENT OF ARTHRITIS—UPDATE;** Category 1 Credit; Contact: Colon H. Wilson, M.D., Emory University School of Medicine, Atlanta 30322.

30-31—*Atlanta;* **PHARMACOLOGY FOR ANESTHESIOLOGISTS;** Category 1 Credit; Contact: John E. Steinhaus, M.D., Emory University School of Medicine, Atlanta 30322.

30-Apr. 1—*Atlanta;* **GASTROINTESTINAL DISEASES;** Approval to be requested from AAFP; Contact: Patsy A. Pennington, Medical College of Ga., Division of Continuing Education, Augusta 30902.

APRIL

3-5—*Atlanta;* **CLINICAL GENETICS FOR THE PEDIATRICIAN;** Category 1 Credit; Contact: Richard W. Blumberg, M.D., Louis J. Elsas, II, M.D., Emory University School of Medicine, Atlanta 30322.

3-5—*Atlanta;* **CLINICAL CYTOPATHOLOGY;** Category 1 Credit; Contact: Zuher Naib, M.D., Emory University School of Medicine, Atlanta 30322.

5-7—*Atlanta;* **TECHNIQUES IN ORTHOPAEDIC SURGERY, IV;** Category 1 Credit; Contact: J. Robin deAndrade, M.D., Emory University School of Medicine, Atlanta 30322.

6-7—*Callaway Gardens;* **6TH ANNUAL CONFERENCE ON PERINATAL MEDICINE;** Contact: Micki L. Souma, M.D., Perinatology, The Medical Center, P.O. Box 951, Columbus 31902.

6-9—*Atlanta;* **ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION;** Category 1 Credit; Contact: Mrs. G. M. Coleman, 1911 Jefferson Davis Hwy., Suite 905, Arlington, VA 22202.

11-12—*Augusta;* **NEONATOLOGY;** Approval to be requested from AAFP; Contact: Patsy A. Pennington, Medical College of Ga., Division of Continuing Education, Augusta 30902.

13-15—*Augusta;* **OBSTETRICS AND GYNECOLOGY;** Approval to be requested from AAFP; Contact: Patsy A. Pennington, Medical College of Ga., Division of Continuing Education, Augusta 30902.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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Kaon® Elixir
(potassium gluconate)

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(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

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tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

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Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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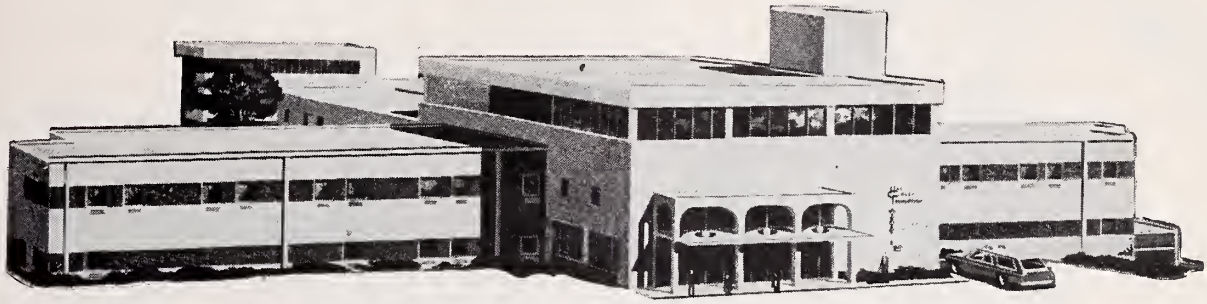
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Reversible Acute Renal Failure Associated with Chlorthalidone Therapy: Possible Drug-Induced Interstitial Nephritis

STANLEY T. PESKOE, M.D., JAMES H. MCMILLAN, B.S.,
ALEXANDER LORCH, M.D., HY SUSSMAN, M.D., TAKESHI OZAWA, M.D., *Augusta**

CHLORTHALIDONE, A MONOSULFAMYL DIURETIC, has been used in the treatment of hypertension. Its use has been associated with a number of adverse reactions, including nausea, vomiting, intrahepatic cholestatic jaundice, pancreatitis, thrombocytopenia, photosensitivity and cutaneous vasculitis. Acute renal failure due to chlorthalidone, however, has not been reported.

In the patient we describe, progressive azotemia developed with chlorthalidone therapy in association with peripheral eosinophilia, hematuria, and proteinuria. His renal disease recovered with the withdrawal of chlorthalidone and the administration of steroid therapy. The possible mechanisms of acute renal failure are discussed.

Report of a Case

A 58-year-old male was admitted to the Veterans Administration Hospital, Augusta, Georgia, for progressive angina refractory to medical therapy. He was known to have had hypertension for at least five years and a mild chronic renal disease, which was thought to be nephrosclerosis. The patient subsequently underwent a three-vessel aortocoronary bypass and recovered uneventfully. Serum creatinine was 2 mg% and urinalysis was normal at that time. The patient was discharged with medications of digoxin, furosemide, and a potassium supplement.

This is the first published report of acute renal failure in which chlorthalidone has been implicated

One month later he was readmitted because of an episode of transient cerebral ischemic attack. Neurological examination did not reveal any focal or lateralizing signs. Laboratory data on admission revealed a hemoglobin of 12 gm%, hematocrit 35.3%, white blood cell count 11,300/cc with 83 polys, 11 lymphs and 6 monos. Glucose was 115 mg%, blood urea nitrogen 50 mg%, Na 138 mEq/l, K 4.4 mEq/l, Cl 94 mEq/l, CO_2 26 mEq/l, and serum creatinine 3.4 mg%. Urinalysis was normal.

His diastolic blood pressure during the first three hospital days ranged between 100 and 110 mmHg. Chlorthalidone, 50 mg daily, was started on the third hospital day when the serum creatinine was 2.6 mg% and the blood urea nitrogen was 45 mg%. When his blood pressure failed to respond to bed rest and diuretic therapy, methyldopa was added to the regimen on the seventh hospital day resulting in good control of blood pressure within several days.

On the 22nd hospital day, serum creatinine was found to be 6.7 mg%. His blood pressure was stable without an episode of hypotension. His weight remained stable. There was no evidence of congestive

* All the authors are associated with the Medical College of Georgia, Augusta, Ga. 30904, in the following capacities: Dr. Peskoe—Internal Medicine Resident; Mr. McMillan—senior medical student; Dr. Lorch—Nephrology Fellow; Dr. Sussman—Associate Professor; Dr. Ozawa—Assistant Professor.

heart failure, volume depletion, or rash. He was never oliguric. Urinalysis revealed a specific gravity of 1.013, negative glucose, and 2+ proteinuria. Microscopic hematuria (4-5 red blood cells per high power field) without cellular casts was noted. Twenty-four hour urine protein was 1.079 mg. Spot urine revealed Na of 63 mEq/l, K of 12 mEq/l and urine osmolarity of 306 mOsm/KgH_2O with plasma osmolarity of 294 mOsm/KgH_2O. An absolute eosinophilia count was 980/cc. His anti-nuclear factor was negative, and his rheumatoid factor was not detected. C3 was 168 mg% (normal 90-190 mg%). Cryoglobulins were not isolated.

An infusion intravenous pyelogram showed poor concentration of the contrast media bilaterally with normal kidney size. There was no evidence of obstruction. Renal venogram demonstrated patent major branches of both renal arteries.

On the 24th hospital day we were requested to see this patient. We raised the possibility of acute interstitial nephritis due to chlorthalidone as the etiology of acute renal failure. Chlorthalidone was discontinued. A renal biopsy was planned to confirm the diagnosis. Prior to the biopsy, however, the patient developed cerebral thrombosis with left hemiparesis. The patient was treated initially with dexamethasone, 4 mg every 6 hours, and further treated with prednisone, 60 mg a day. His renal function recovered remarkably as illustrated in the figure, after the withdrawal of chlorthalidone and the administration of steroid therapy, despite the continuation of other drugs.

Comment

Acute interstitial nephritis induced by drugs has become a well recognized cause of acute renal failure over the past decade.[1–5] The clinical manifestations of this renal disease include fever, morbilliform skin rash, eosinophilia, proteinuria and hematuria in association with increasing blood urea nitrogen and creatinine.[1–5] This disease tends to occur more commonly in patients who have underlying renal diseases.[4] Prompt response to steroid therapy is a well-known characteristic.[4, 5]

Drugs associated with acute interstitial nephritis include sulfonamides, methicillin, allopurinol, phenindione, azathioprine and the sulfonamide derivative diuretics, furosemide and thiazides.[1]

In this case, the obvious causes of acute renal failure such as urinary obstruction, severe hypertension and congestive heart failure were excluded. Though he was on the diuretic, there was no evidence of volume depletion. His weight was stable during the episode of acute renal failure. Mild vasomotor nephropathy is possible, but there was no episode of hypotension nor evidence of hemoglobinuria or myoglobulinuria. Renal vein thrombosis was excluded by venogram. Although other causes of acute renal failure such as collagen vascular diseases, nonspecific vasculitis, acute glomerulonephritis and renal artery occlusion are possible, acute renal failure associated with a sudden onset of microscopic hematuria, proteinuria and peripheral eosinophilia, and the prompt response to steroid therapy make these possibilities unlikely. We feel that the diagnosis of acute interstitial nephritis is justified by the typical features in this case. The causative agent seems to be chlorthalidone since the renal function of this patient recovered, as well as the disappearance of hematuria, proteinuria and peripheral eosinophilia, after the withdrawal of chlorthalidone and in spite of the reinstitution of other medications.

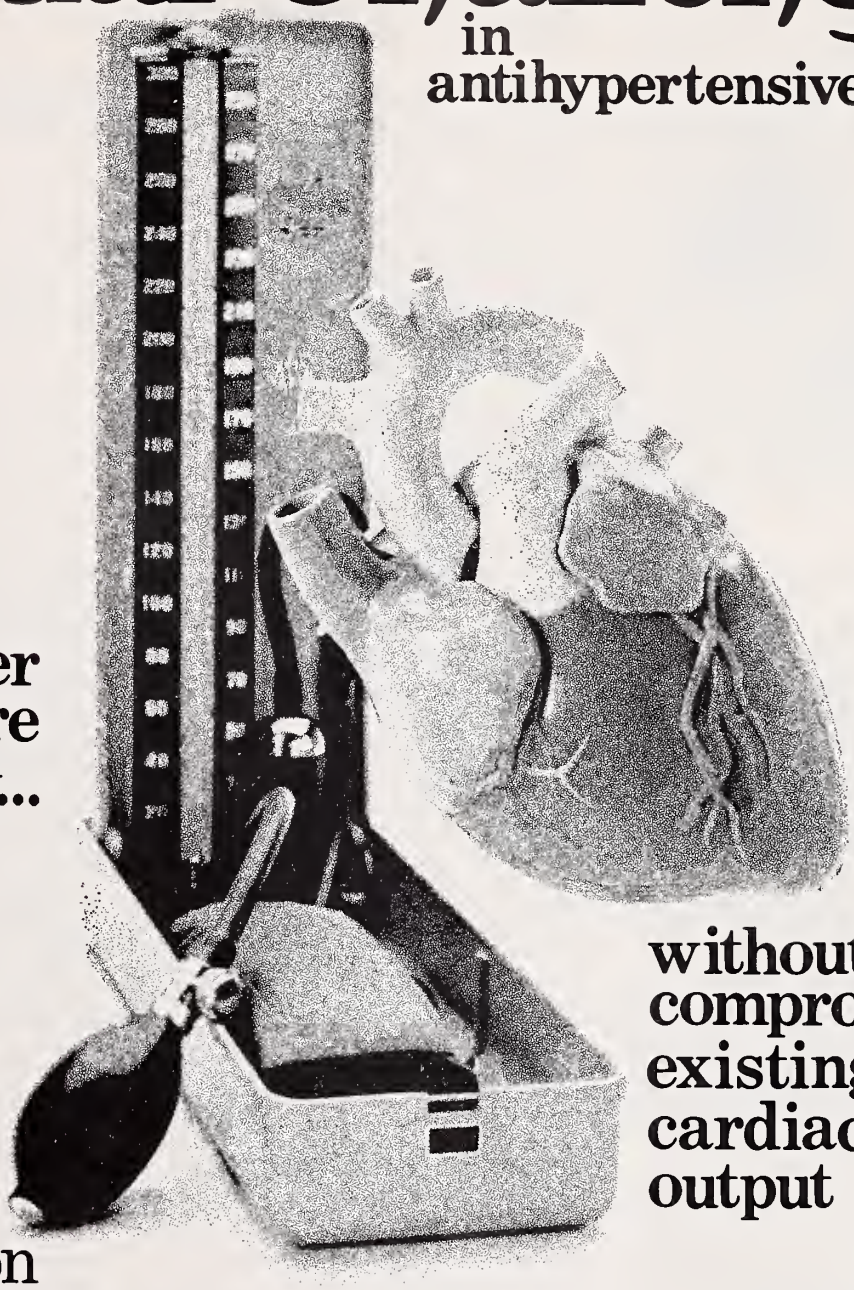
Our purpose in this brief report is to suggest that chlorthalidone may possibly induce acute interstitial nephritis resulting in acute renal failure. This renal failure may be reversible by the withdrawal of this drug and the administration of a steroid. We also wish to alert clinicians to the potentially reversible side effect of chlorthalidone.

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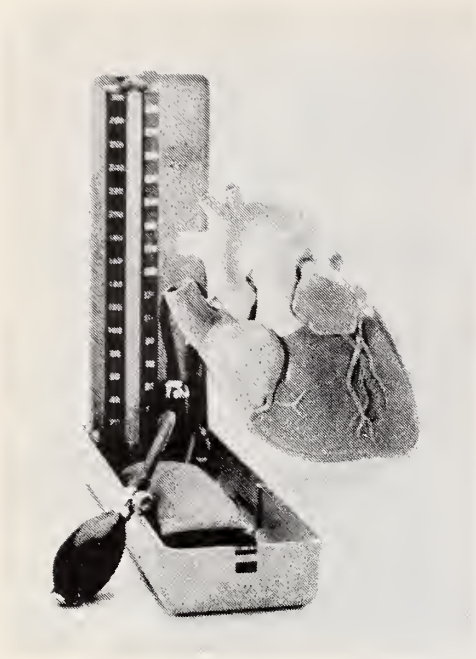
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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

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Clinical Infections and Antibiotics

WILLIAM E. MITCHELL, JR., M.D., *Atlanta**

WE HAVE RECENTLY reported antibiotic sensitivity data in hospital acquired infections at a 419 bed community hospital for the calendar year 1975.[1] In the present article we will expand this information to include both community and hospital acquired infections for 1976. Instances where there are significant differences in antibiotic sensitivities between community and hospital acquired infections are noted. We hope that practicing physicians who do not have access to the facilities and expertise of an infectious disease department will find our information useful as an adjunct to the other widely available resource materials listed in the bibliography.[2–8]

Methods

Standard Kirby-Bauer antibiotic sensitivity techniques were used. Data were compiled and analyzed using manual methods described previously.[1] We recognize that some of the organisms may have been contaminants and/or colonizers rather than contributors to actual clinical infection. Attempting to identify and exclude such cultures seemed to introduce an unknown degree of subjectivity and therefore this was not done except for sputum cultures where the organism in question accounted for no more than 5% of the colonies. All other organisms cultured from clinical infections are included.

Our data are for *in-patient* cultures only, and an unknown number of mild to moderate infections which were treated on an out-patient basis are not included in the calculations. Therefore our data reflect those community-acquired infections of a severity sufficient to require hospitalization and are not a valid sample of *all* community acquired infections. Not all Gram (+) cocci were tested against Tobramycin but our data are consistent with the general observation that organisms sensitive to Gentamicin are also sensitive to Tobramycin. Nevertheless, since our own data are incomplete, Gram (+) cocci sensitivity percentages for Tobramycin are enclosed in parentheses ( ) to indicate that they are estimated rather than observed figures. Sensitivities were not routinely performed on Haemophilus, Streptococcus Pneumoniae, or Group A Beta Streptococcus since the sensitivity of these organisms to various antibiotics is generally agreed to be uniform. In the last two years we have had a sharp increase in the number of Bacteroides identified, probably as a result of improved specimen collection and culture techniques. Standard sensitivity testing is not reliable for these anerobes, and in an attempt to adjust for this, we have assumed that 75% of Bacteroides will be sensitive to Chloramphenicol and Clindamycin.

Since there are generally few clinically significant differences among chemically similar antibiotics, we feel that for purposes of estimating the likelihood of clinical effectiveness, antibiotics can be grouped as follows:

1. *Tetracycline group:* Tetracycline, Chlor and Oxytetracycline, Declomycin, Vibramycin, Rondomycin, Achromycin, Terramycin, Minocin, Aureomycin, etc.
2. *Cephalosporin group:* Keflin, Keflex, Lorindine, Kafocin, Ancef, Kefzol, Cefadyl, etc.
3. *Clindamycin group:* Lincomycin, Lincocin, Clindamycin, Cleocin.
4. *Semisynthetic Penicillins:* Methicilllin, Oxacillin, Cloxacillin, Dicloxacillin, Nafacillin, Tegopen, Veracillin, Staphcillin, Unipen, Prostaphlin, etc.

Results

Data for community and hospital acquired infections are presented as a composite figure where there is no significant difference between the two. Where there *is* a difference, data is presented as (Community/Hospital). Data are presented in three tables which are arranged according to the information already available to the physician. If the site of infection is known but for some unusual reason it is not possible to obtain a gram stain, use Table 1. In the usual situation where a gram stain is available or can be obtained, use Table 2. If the organism has been identified but sensitivities are not yet available, use Table 3. When actual sensitivity information is available at the initiation of therapy, it would always be more appropriate to use that information than any of the Tables.

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TABLE 1

SITE OF INFECTION KNOWN, BUT NEITHER IDENTIFICATION NOR GRAM STAIN AVAILABLE
Likelihood of organism being sensitive to each antibiotic by site:

WOUND†		URINE†		RESPIRATORY†	
Antibiotic	% Sensitive	Antibiotic	% Sensitive	Antibiotic	% Sensitive
Chloramphenicol	89	(Tobramycin	94)	Gentamicin	93
Gentamicin	83	Gentamicin	92	(Tobramycin	92)
(Tobramycin	83)	Chloramphenicol	85	Chloramphenicol	83
Cephalosporin grp.	72	Kanamycin	73	Kanamycin	80
Kanamycin	71	Cephalosporin grp.	70	Colimycin	77/60*
Tetracycline grp.	57	Septra/Bactrim	59	Cephalosporin grp.	68
Clindamycin grp.	48/62*	Colimycin	55	Tetracycline grp	66
Erythromycin	45	Nalidixic acid	50/59*	Carbenicillin	45
Ampicillin	39	Tetracycline grp.	50	Ampicillin	44
Semisynthetic penicillins grp.	39	Sulfisoxazole	48	Erythromycin	29
Colimycin	31/48*	Carbenicillin	48	Others under	15
Carbenicillin	24	Nitrofurazone	43		
Penicillin	13	Ampicillin	43		
		Clindamycin grp.	28		

† Assumes Beta Strep. and Strep. Pneumonia sensitive to usual gram (+) effective antibiotics and Haemophilus uniformly sensitive.
* Community %/hospital %.

Discussion

The recently published "Audits of Antimicrobial Usage" have emphasized the importance of rational antibiotic therapy.[9] No antibiotic is without significant side effects, and the changing nature of infections in the community and hospital environments make it essential for physicians to order antibiotics with due regard for the probable sensitivity of the organism involved as well as the complications and cost of the therapy. Many clinicians have found the type of information presented in this article helpful in actual clinical practice, but infectious disease specialists have expressed the reasonable concern that continued dissemination of this information without qualifying comment might increase inappropriate use of toxic antibiotics such as the aminoglycosides and Chloramphenicol. We believe that this danger can be minimized if clinicians who use the tables will keep the following observations in mind:

1) Initial antibiotic therapy of a significant infection should be based on a prompt gram stain. For various reasons, this is not always possible, but failing to do a gram stain really must be viewed as what it is—an acceptance of less than optimal care.

2) Chloramphenicol is rarely the "drug of choice" in either community acquired or hospital acquired infections, and its rare but devastating toxicity must always be kept in mind. Most experts agree that Chloramphenicol should be used only for potentially life-threatening infections and/or when other less toxic antibiotics have been, or seem very likely to be, ineffective.

3) All aminoglycosides (including the recently released Amikacin) have serious toxicities and should be reserved for serious infections rather than used for mild to moderate infections and/or prophylaxis, except when less toxic antibiotics are *known* to be ineffective.

4) In the management of an individual case, no data table can ever reduce the importance of careful information-gathering, mature clinical judgment and appropriate consultation with an expert in infectious diseases.

5) Data such as ours may well raise more questions than they answer. For example, why do some organisms seem to show greater sensitivity to antibiotics when acquired in the hospital than in the community, when just the opposite would be expected? (We suspect that this may be related somehow to host resistance and/or other patient characteristics.) Also, are the observed variations in resistance to antibiotics random fluctuations, or sampling errors, or are they indicative of long-term sustained change in bacterial resistance, perhaps related to antibiotic "pressure"? It seems likely that only a carefully controlled and rather sophisticated analysis of variations over a number of years will permit firm answers to these questions.

Physicians who find our data useful should consider accumulating similar data for their own hospitals, since there *may* be significant variations in sensitivity to antibiotics in other geographical areas and in hospitals with different patterns of antibiotic usage.

TABLE 2

SITE AND GRAM KNOWN—NEITHER IDENTIFICATION NOR SENSITIVITY KNOWN

A. Wound Organisms

Gram (–) Rods

E. coli	50
Proteus	32
Bacteroides	23
Klebsiella	15
Enterobacter	14
Pseudomonas	10
Others	10

Gram (+) Rods

Staph. epi	53
Staph. aureus	43
Enterococcus	25
Alpha Strep. (not D)	7
Beta Strep. (not A, B or D)	6
Others	18

B. Urinary Tract Organisms

Gram (–) Rods

E. coli	168
Proteus	58
Pseudomonas	46
Klebsiella	37
Enterobacter	22
Serratia	10
Citrobacter	4
Others	2

Gram (+) Cocci

Enterococcus	77
Staph. epi.	28
Alpha Strep. (not D)	16
Alpha Strep. (D)	8
Staph. aureus	8
Others	10

C. Respiratory Tract Organisms

Gram (–) Rods

Hemophilus	95
E. coli	78
Klebsiella	60
Pseudomonas	55
Enterobacter	49
Proteus	29
Serratia	24
Acinetobacter	12

Gram (+) Cocci

Staph. aureus	43
Beta Strep. (not A, B, D)	13
Strep. Pneumoniae	10
Staph. epi.	7

Likelihood of Sensitivity to Each Antibiotic†

Gram (–) Rods	% Sensitive
Chloramphenicol	82
Tobramycin	83/73*
Gentamicin	79
Kanamycin	76/56*
Carbenicillin	65
Colimycin	64
Cephalosporin grp.	60/46*
Tetracycline grp.	51/38*
Ampicillin	39

Likelihood of Sensitivity to Each Antibiotic†

Gram (+) Cocci	% Sensitive
Chloramphenicol	96
Cephalosporin grp.	92
Clindamicin grp.	89
Erythromycin	86
Gentamicin	84
(Tobramycin	84)
Semisynthetic penicillin grp.	74
Kanamycin	70
Tetracycline grp.	61/72*
Ampicillin	41
Penicillin	24

Gram (–) Rods	% Sensitive
Gentamicin	97
Tobramycin	97
Septra/Bactrim	84
Kanamycin	82
Chloramphenicol	80
Colimycin	78
Nalidixic Acid	71/88*
Sulfisozole	69
Cephalosporin grp.	68
Carbenicillin	68
Nitrofurantoin	62
Ampicillin	46

Gram (+) Cocci	% Sensitive
Chloramphenicol	94
Clindamycin grp.	90
Erythromycin	85/96*
Gentamicin	79
Tobramycin	79
Cephalosporin grp	76/65*
Kanamycin	49
Tetracycline grp.	35/45*
Ampicillin	36
Semisynthetic penicillin grp.	33
Penicillin	18

Gram (–) Rods	% Sensitive
Gentamicin	97
Tobramycin	96
Colimycin	69/91*
Kanamycin	83
Chloramphenicol	80
Tetracycline grp.	68
Cephalosporin grp.	63
Carbenicillin	53
Ampicillin	44
Erythromycin	18

Gram (+) Cocci	% Sensitive
Chloramphenicol	99
Erythromycin	96
Clindamycin grp.	94
Cephalosporin grp.	92/69*
Semisynthetic penicillin grp.	92/67*
Gentamicin	71
Kanamycin	68
(Tobramycin	68)
Tetracycline grp.	55
Ampicillin	42
Penicillin	27/55*

† Assumes Beta strep and Strep Pneumoniae sensitive to usual gram (+) effective antibiotics, and Haemophilus uniformly sensitive.

* Community %/Hospital %.

NT—Not tested.

TABLE 3

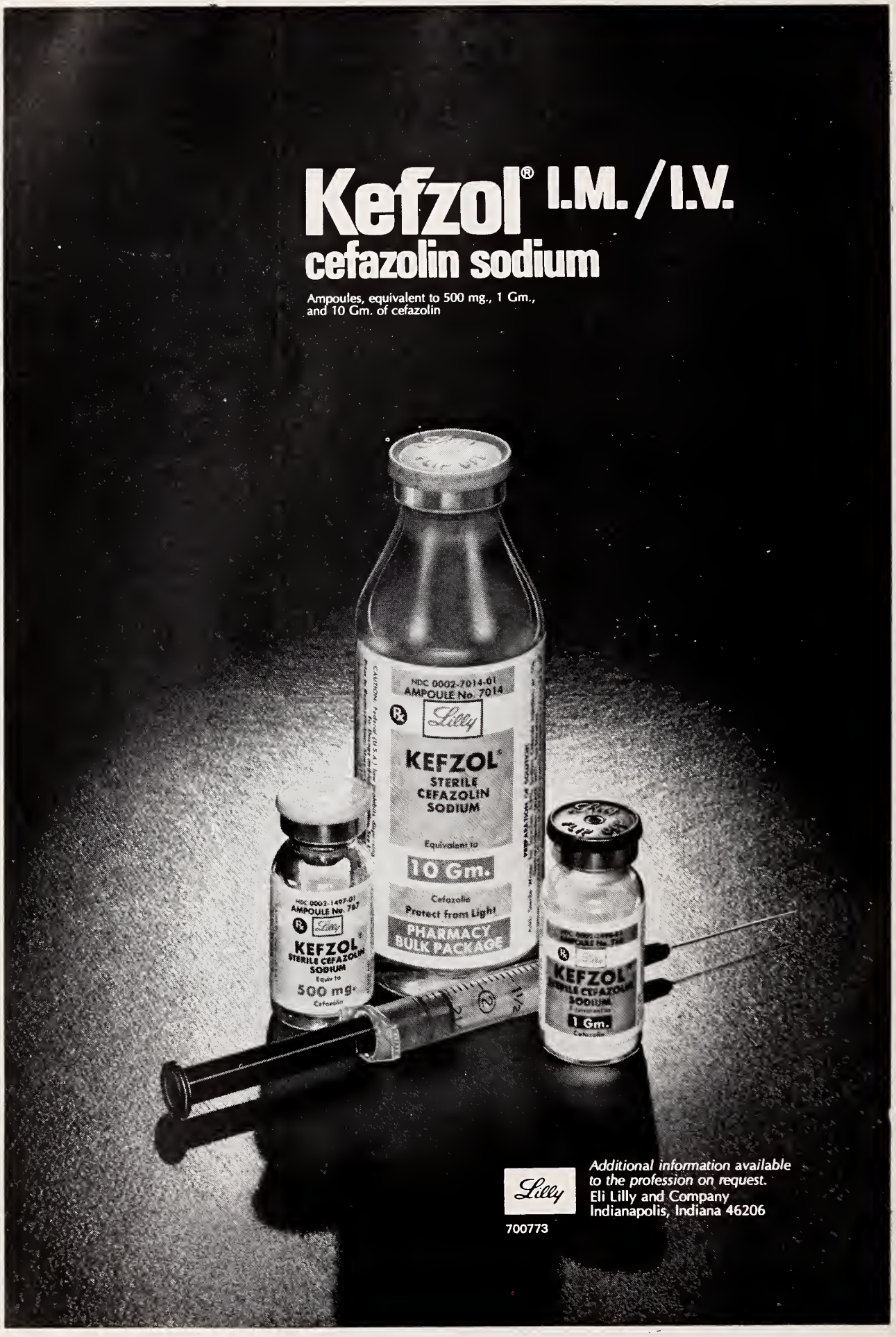
ORGANISM KNOWN BUT SENSITIVITIES NOT REPORTED
OVERALL SENSITIVITIES, ALL ORGANISMS, ALL SITES

Antibiotics	Organisms														
	Acinetobacter	Citrobacter	E. Coli	Enterobacter	Klebsiella	Proteus	Pseudomonas	Serratia	S. Aureus	S. Epidermidis	Enterococcus	Beta Strep., Grp. B	Beta Strep., not Grp. A, B, or D	Alpha and Nonhemol. Strep., Grp. D	Alpha and Nonhemol. Strep., Not Grp. D
Ampicillin ...	14	40	72	11	0	67	0	10	20	58/70*	13	100	77/100*	47/83*	79/50*
Carbenicillin .	100	80	88	67/88*	18/28*	95	34	94/71*	NT	NT	NT	NT	NT	NT	NT
Cephalosporin grp. .	21	40	90	90	93	82	1	30/0*	99	99	60/44*	100	94	94/67*	91
Chloramphenicol	42	80	97	27/6*	95	91	5	63/100*	100	93	97	100	100	96	100
Clindamycin grp.	NT	NT	NT	NT	NT	NT	NT	NT	99	83	90	100	69/100*	78	79/100*
Colimycin ...	100	100	99	89	99	4	97	79/57*	NT	NT	NT	NT	NT	NT	NT
Erythromycin	NT	NT	NT	NT	NT	NT	NT	NT	100	75	93	100	77/100*	76/100*	86/100*
Gentamicin ..	78	80	99	99	99	97	95	93	100	95	75	75	31/75*	69	86/63*
Kanamycin ..	86	100	96	97	97	93	11	91	98	77	41	13	23/50*	31	64/50*
Penicillin	NT	NT	NT	NT	NT	NT	NT	NT	10	25/41*	2	75	61/100*	35/67*	64/38*
Semisynthetic penicillin grp.	NT	NT	NT	NT	NT	NT	NT	NT	98	82/93*	8	100	77/100*	32/17*	57/100*
Tetracycline grp.	71	90	77	77	94	35/24*	12	70/57*	89	58/81*	21/53*	25	53	47/67*	78
Tobramycin .	86	96	97	97	99	95	95	95	NT	NT	NT	NT	NT	NT	NT
Urinary Tract Only															
Nalidixic acid	100	66/100*	96	95	94	0	88/100*	NT	NT	NT	NT	NT	NT	NT	NT
Nitrofurantoin ..	75	99	48	59	30	0	9	NT	NT	NT	NT	NT	NT	NT	NT
Septra/Bactrim ...	100	99	99	95	92	4	88/100*	NT	NT	NT	NT	NT	NT	NT	NT
Sulfisoxazole ...	100	82/65*	82	88/70*	80	0	77/100*	NT	NT	NT	NT	NT	NT	NT	NT

* (Community %/Hospital %).
NT—Not tested.

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Obstructive Jaundice

GEORGE W. VEALE, M.D., NARUMOL SRISUTHAPAN, M.D., *and*
AYTEN SOMEREN, M.D., *Atlanta**

Dr. George Veale: The patient is a 62-year-old female who was referred from a nursing home with a three week history of nausea, vomiting and jaundice. She had been in good health until two weeks prior to admission when she developed urticaria. Her nausea and vomiting increased to 3-4 times a day two days prior to admission. The patient lost 20 pounds in the past year.

On physical examination, a 5 x 6 cm. smooth, non-tender mass was palpated in the right upper quadrant.

The lab values are SGOT 151-171, Alk. Ptase. 248-272, total bilirubin: 5.5 (direct 4.8) $\rightarrow$ 9.0.

Dr. Narumol, will you please comment on the films?

Dr. Narumol Srisuthapan: The upper G.I. series shows a mass defect on the duodenal bulb and the appearance and location suggest compression by the gallbladder. There is no widening or mucosal destruction of the descending duodenum. In a jaundiced patient with a palpable right upper quadrant mass, an enlarged gallbladder should be suspected.

Normally, an oral or intravenous cholecystogram would be done, but because the total serum bilirubin is above 4 mg%, the gallbladder would not generally visualize. Percutaneous transhepatic cholangiography is the method of choice for determination of intrahepatic or extrahepatic jaundice.

The percutaneous transhepatic cholangiogram (Fig. 1) demonstrates a constrictive lesion, approximately 1 cm. in length, in the proximal common bile duct. There is moderate dilatation of the right and left hepatic radicals. The distal common bile duct remains normal in caliber and drains normally into the duodenum. I cannot appreciate any opacification of the cystic duct or gallbladder.

In giving a differential diagnosis of common bile duct obstruction, the most common finding would be a biliary tract calculus. However, a stone would give a typical well-defined intraluminal defect which is not seen in this case. With no history of surgery, stricture of the common bile duct is unlikely. Sclerosing cholangitis could give a similar, constrictive appearance but usually it would involve both intrahepatic and extrahepatic ducts with absence of any intrahepatic duct dilatation.

Among primary tumors of the biliary tract, adenocarcinoma is a common malignant tumor. It is usually a scirrhous, mucin-producing tumor arising from the common bile duct or the junction of the main hepatic duct and cystic duct.

Carcinoma of the gallbladder is also a fairly common tumor, but rarely preoperatively diagnosed. When the tumor extends from the infundibulum into the cystic duct, the findings will be a nonfunctioning enlarged gallbladder.

Metastatic tumor, commonly from pancreatic carcinoma, will often encircle the common bile duct, producing an asymmetrical narrowing. Sometime evident is an associated mass and duodenal mucosal invasion. In chronic pancreatitis, periductal inflammation will cause a smooth, constrictive gradually tapering segment.

In conclusion, the x-ray findings in this patient suggest the jaundice is due to a primary tumor, either arising from the common bile duct near the cystic duct or occurring in the gallbladder and extends into the cystic duct producing obstruction.

Dr. Veale: This patient had an ultrasound examination which showed a density casting an acoustic

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shadow which could not be separated from the region of the cystic duct or common duct. Multiple calculi are seen in the gallbladder but no definite common duct stone is identified (Fig. 2). How does this affect your differential diagnosis?

Dr. Narumol: I would not be surprised. The incidence of calculi with carcinoma of the gallbladder is about 80-90%. Also, the tumor itself might produce an echo resembling a stone.

Dr. Veale: Surgical resection of the gallbladder and common bile duct was done and a hepaticojejunostomy was performed. Dr. Someren, would you comment on the pathological findings?

Dr. Ayten Someren: The gross specimen consisted of a gallbladder measuring 8 x 4 x 3 cm. in the unopened state. Upon opening, the gallbladder was found to contain yellowish creamy material, and a single stone measuring 9 x 8 x 5 mm. A portion of the gallbladder wall was thickened up to 1.2 cm. and had a firm yellowish-tan appearance on cut surfaces. This area measured approximately 7 x 3 x 1.2 cm. and extended from the fundus to the gallbladder neck.

Microscopically, the lesion proved to be a well-differentiated adenocarcinoma of mucin-secreting type, extensively involving the gallbladder wall. The tumor was present in all portions of the gallbladder wall, including the grossly unremarkable areas, extending to the neck and cystic duct. Adjacent portions of the liver tissue removed with the gallbladder were also invaded.



Fig. 1—Percutaneous transhepatic cholangiogram demonstrating 1 cm. constrictive lesion in the proximal common bile duct (arrows).

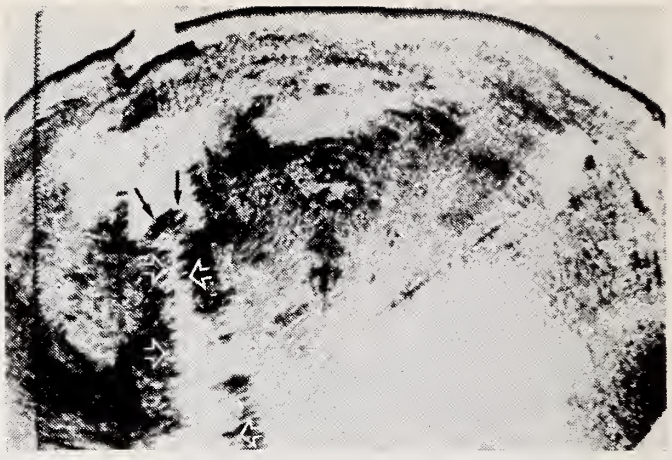


Fig. 2—Ultrasound scan demonstrating stone (arrow) within gallbladder with characteristic acoustic shadows projecting posteriorly (open arrows).

Unfortunately this patient expired approximately 12 days postoperatively. At autopsy, there was microscopic evidence of residual tumor localized at the porta hepatis area, with extension into the adjacent liver. Most of the residual tumor was located at the perineural spaces. No evidence of metastatic disease was present.

Discussion

Carcinoma of the gallbladder occurs predominantly in women (ratio 5 : 1), usually past 50 years of age. Gallstones are present in 80-90% of cases. Repeated observations strongly support the concept that carcinoma of the gallbladder is related to long-standing cholelithiasis. Preponderance of gallbladder carcinoma in women has also been considered a consequence of the greater frequency of gallstones in this sex.

Clinical history of nausea and vomiting, obstructive jaundice and 20-pound weight loss, as well as a palpable mass in the area of the gallbladder on physical examination, as in this case, constitutes a fairly typical clinical presentation for carcinoma of the gallbladder.

Grossly, the lesions may not be very apparent, in the absence of a large papillary infiltrating or ulcerating mass. They may be diffuse or localized.

Microscopically, they are either adenocarcinomas, or less commonly, squamous-cell carcinomas. Rare mixed forms (adenosquamous carcinomas) also occur. Tumors frequently spread through the wall of the gallbladder and invade the surrounding structures, including liver and pancreas. Because of this, they are rarely resectable completely. This

spread outward from the mucosa may be via lymphatics, perineural spaces or by blood vessels. Simultaneous lesions grow widely over the mucosa, with extension down to the cystic duct, and occasionally into the common duct. Spread to distant organs is also not rare.

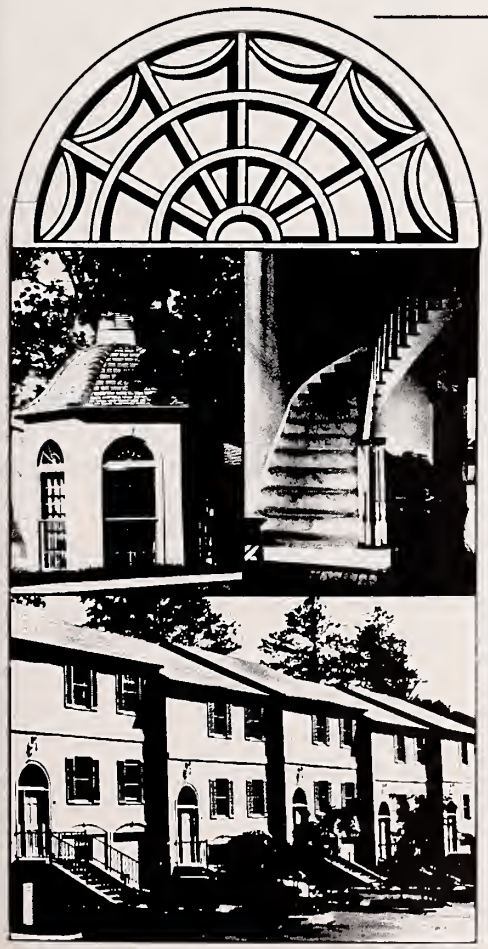
Complications include perforation, fistula formation into the duodenum, stomach or colon, obstruction of pylorus or duodenum.

The prognosis of gallbladder carcinoma is very poor and the only patients ever cured have been those in whom carcinomas were found incidentally. The few long-term survivors are those who have well-differentiated papillary adenocarcinomas. Treatment is surgical, provided that surgery is possible at the time the tumor is recognized.

Diagnosis of etiologies of obstructive jaundice has been enhanced by new and innovative techniques. Among these are percutaneous transhepatic cholangiography, selective angiography, ultrasound, endoscopic retrograde cholangiopancreaticogram (ERCP) and Rose Bengal scan. Used together, these diagnostic procedures have aided in pre-operative classification of obstructive jaundice.

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Report from the Mother Country

HARRISON L. ROGERS JR., M.D., *Atlanta**

THE AMA DURING 1976 and 1977 sent the Board of Trustees and certain of the staff of the organization to England for an "on the scene" evaluation of the *N*ational *H*ealth *S*ervice. As a new board member (ex officio), I was asked to join the trip scheduled for November 1977. Our "planned activities" commenced Monday morning and continued until Friday afternoon. Initially, we had a historical review of the NHS prior to 1948, as well as subsequent to that date, presented by the staff of the organization which developed our meeting for the AMA (Economic Models Limited).

The following day, we heard from advocates and opponents of NHS, including a local public health doctor, a physician member of Parliament who was a vigorous advocate of the NHS, a general practitioner and finally a consultant who was a vigorous opponent of NHS. The following two days were filled with visits to a London teaching hospital (Guy's Hospital) and a community hospital and community health facility (High Wycombe). Included was an hour-long meeting with the Minister of Health, Mr. Moyle, who earlier had met with Mr Califano (Secretary of HEW). On the final day of our meeting, we met with representatives of the Health Department, the largest private health insurance company (BUPA) and a representative of the Patients' Association.

Several considerations which were alien to U.S. Medicine were apparent early in our meeting. The sharp division present in British medicine between the general practitioner and the hospital physician or consultant was described in detail. Traditionally, health care outside the hospital is delivered by the GP to the total exclusion of the consultant. Similarly, the GP does not offer health care in the hospital, and there are few instances where this general rule is broken. In the past, the British Medical Association has represented largely the GPs, with the consultant having no comparable organization until very recently.

The general practitioner is the point of access to the health care system except in an emergency, when direct service at a hospital emergency department is available. Everyone in England is "registered" with a GP and receives *all* his care by this doctor, unless he is sent to a hospital. The GP has little or no equipment for diagnosis and treatment and usually must send his patient to a hospital for laboratory, X ray, cytologic or other diagnostic procedures. A fair amount of his time is occupied with writing out prescription refills, sickness or disability forms, and, in addition, he makes house calls on his patients fairly commonly.

The GP entering practice is "encouraged" to open his office in an area with few doctors and is refused permission to enter practice in an area with too many GPs. The patient *and* the GP *both* have the option to select or leave one another under the present system. The GP maintains a "list" of patients for whom he is responsible 24 hours a day, and he is paid a "capitation" fee of from $4.00 to $7.50 to care for that patient for one year—regardless of the service provided. There is no control on utilization (except for the length of time spent waiting for service).

There are 50,000 doctors in England, of whom nearly half (22,000) are GPs, 15,000 are consultants and about 13,000 are in hospital training programs. The GP has an average income of $15,750, which is close to the average for attorneys and accountants. The consultant may earn from $13,000 to $18,700, with the salary of the physician in his last year of hospital training likely larger than it will be the following year when he reaches consultant status (primarily because the House Officer is now paid for overtime after going on strike several years ago).

The consultants include 1,300 general surgeons, 1,100 pediatricians, 800 Ob-Gyn and 475 internists. They usually spend most of their time on National Health Service patients and reserve a small percentage (10% or less) for private patients. Current government policy is aimed at eliminating the 1% of NHS hospital beds (4,000 of 400,000) which are reserved for the consultants' private patients and, in addition, making the construction and licensing of private hospitals very difficult.

In general, as we listened to the various people speaking with us, it seemed that the patients are quite satisfied with the level of care they receive. It was our opinion that this level of care is *far below* the average received by U.S. citizens and would be poorly accepted by the U.S. citizen. It seemed that many reasons existed for this acceptance by the British patients, including primarily the fact that they have never known a different level of care and, in addition, demonstrate a tolerance for central direction not found here. Basically, it is the providers who complain about the NHS —and the loudest complaints come from the consultants and educators.

I was surprised to learn that, in fact, the current NHS is not really

* Vice Speaker, House of Delegates, American Medical Association. Dr. Rogers' address is 1938 Peachtree Rd., NW, #601, Atlanta, Ga. 30309.

so innovative in England, and that for 35 years prior to passage of NHS in 1948, over half the population had been covered for primary medical care and certain other types of care. Many GPs had been on a capitation fee system throughout this period and consequently noted little change after 1948. During this time, many hospitals were "voluntary" (supported by charity and to a lesser extent by local governments), with the patient paying very little toward his hospital bill and usually receiving the consultant's service free. As a matter of fact, in 1948 when Mr. Bevin offered a salary to the consultants, many were concerned that being paid for services "volunteered" in the past might be unethical! This concern evaporated and was replaced with acceptance, as long as the government left their limited private practice alone!

With the problems presented the British people by World War II, the "Blitz" and their very real proximity to war, the need for central planning for the health needs of the civilian and military population was accepted. The "market" determination of need for service was felt inadequate for war and carried over into the post-war period. The national acceptance of communal health care standards was probably related to the common survival problems faced during war time.

From 1948 to 1974, the NHS administrative structure was split into three distinct areas: the GP, the teaching hospitals and regional hospitals, and because of great complaints about difficult administration, reform legislation was adopted. This put all health care under one central "roof"—GP and hospital doctor alike—with an administrative structure developed including regional, area and district levels of administrators. This structure has received bitter criticism from physicians and administrators alike, concerned with the *great* increase in the number of non-service personnel, as well as the absolute destruction of the responsible single administrator, for now all decisions are made by "consent" within a committee structure that is cumbersome and very slow in operation. A Royal Commission has been established to evaluate this new system.

With all the preceding as background, advantages of the NHS were pointed out:

1. Cost is not a factor to the patient, and cost is *absolutely* controlled by the government.

2. Access to system is good and quality is fairly standard.

3. Training facilities good.

and disadvantages:

1. Morale is *very* low with consultants, as well as most hospital personnel.

2. Administrative changes have decreased the authority of the consultant.

"The GP maintains a list of patients for whom he is responsible 24 hours a day, and he is paid a fee of from $4.00 to $7.50 to care for that patient for one year—regardless of the service provided"

3. Standards of care are *falling* and the patients are *not* aware of this. The supply of nurses is very short and their quality less than ideal. Operating rooms are running at only part of their capacity (shortage of nurses). Intensive care units closed for a month (personnel shortage). No new facilities, money being spent on the new administrative structure instead of services. Workers in health field have increased from 400,000 to 700,000 from 1948 to 1972. No continuity of care in hospitals, transfers, resignation of nurses and other personnel.

4. Delay in service to patients: months for routine consultation—several weeks for suspected cancers! Because of the delay, the quality and duration of the individual consultation is brief. Diagnostic facilities are *very* limited. 599,000 people on waiting list for elective admissions to hospitals!

5. Physician's dissatisfaction, in addition to above: he feels he can't do an adequate job; long hours, little reward; no incentive for greater productivity; committee work is not paid for and is taking larger and larger amount of time.

Disparity in priorities: medical staff increased 16% since 1974; administrative staff increased 50%.

Typical allocation of money in teaching hospital: St. Thomas, $4,000,000—Medical Service; $3,500,000—Administrative Service.

General attitude of government is to discourage private practice.

The advice given by the British doctors included:

1. Keep politics out of medical decisions *at all costs.*

2. Obtain public support for position of organized medicine.

3. Maintain private health insurance companies.

4. Avoid bureaucratic excesses, legislatively.

5. *Keep united front,* between general practitioners/specialists as well as private M.D./academic M.D.

6. Keep patient's care uppermost in the goals for organized medicine.

As U.S. physicians look at health care delivered in England, the most striking difference from our own system is the sharp division between hospital and non-hospital physicians and their subsequent lack of unity as they faced a determined central government. The historical acceptance by British physicians of federal health financing schemes, prior to the passage of NHS legislation in 1948, made their opposition ineffectual. We can see in our own PL 93-641 a plan for the federalization of health care in our country very similar to the reorganization of NHS in 1974—with all its shortcomings that are so apparent to physicians and other health professionals in England today.

In spite of the faults we saw in the NHS, from the poor quality to the long waiting lists, the British public seems satisfied with the care they are given. As one of the NHS critics told us "the quality of care is deteriorating precipitously and the patients are not aware of it."

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Georgians Testify Against National Health Insurance

The U.S. Department of Health, Education and Welfare has been holding public hearings across the country on the subject of national health insurance. In Georgia, hearings were held in Albany on October 26, and in Atlanta on October 28. Quite a few MAG members testified at these hearings. Following are excerpts and summaries of some of these testimonies. For a summary of Dr. Robert Perry's testimony, given as the official MAG position, see the December 1977 issue of the *Journal,* page 985.

(Editor's Note: Due to space limitations, all of the testimonies are not included. Testimonies were selected in the order in which they were received in the Journal *office.)*

L. H. FELDER, M.D.
Atlanta

"NHI in any form that would put the government in the position of doing for an individual what he could do for himself will result in his being demoralized"

THE STRENGTH of any society ultimately will come to depend on the satisfaction that individuals in that society find with each other. Any forces that are devisive and productive of hostility between individuals weaken the society. It goes without saying that for any individual to be happy with himself in a society, he has to achieve some measure of self sufficiency in order to be part of the solution and not part of the problem. It's clear that if one is relieved of the responsibility for himself, he is likely to exhibit some irresponsible conduct. National health insurance in any form that would put the government in the position of doing for an individual what he could do for himself will result in his being demoralized. National health insurance, as has been proposed by the Administration and various Congressmen, would in addition to being demoralizing, be degrading, disappointing and frustratingly dysfunctional.

It is common knowledge that approximately half of the visits to a primary care physician are sought by patients who have no significant structurally destructive disease. These people, wittingly or unwittingly, are not looking for a health care system: They are looking for a physician—a person who can separate their physical problems from their mental and emotional problems, and who can be an effective force in dealing with either, while at the same time protecting the patient's sense of worth. Depersonalizing medical care by "plugging the consumer into the health care delivery system" would therefore render half the visits to primary care physicians, a catastrophe for the patient.

It is critical to the subject to consider why physicians went into the field of medicine in the first place. There are perhaps two reasons. Number one could be said to be money. Number two could be said to be self gratification. It is not likely anyone in his right mind would think that physicians who went into medicine prior to 1966 did so primarily for monetary gains. In regard to self gratification, one might say that physicians had a great desire to help other people, or one might say that facing the monstrous challenge of so rigorous a discipline was necessary for the physicians own ego gratification. On either end of this spectrum of self gratification for the physician, the patient benefits. Consider the magnitude of the compliment a patient pays his physician when he spontaneously and completely of his own free will walks into his physician's office and signs in. The compliment he pays the physician should be, and virtually always is, a tremendous stimulation, motivating the physician to give that person his best efforts. Nullification of the gratification a physician gets practicing medicine will simply result in a different kind of person entering medical school. The changes that would ensue thereupon are quite obvious.

Many of the other aspects of national health insurance are well known to people in the field of medicine, as well as any clear-thinking individual, particularly if he has had any experience with government medicine in one of the branches of the service. The increased discomfiture of people finding their most intimate possessions, their body, their thoughts and their feelings, subjected to governmental controls will result in increased petitioning for physician's services. The physician being deprived of satisfaction for rendering these services will likely request increased consultations.

It is well known that the greatest deterrent to malpractice suits is mutually satisfactory interpersonal relationship between the patient and the physician. Loss of this will result in more defensive medicine, greater numbers of tests, less individualization of medical care and an expense that is almost ludicrous to consider. It is clear that without all these autocatalysing, self-fulfilling prophe-

sies that this nation couldn't afford national health insurance even at the current health care bill because it would add an enormous administrative cost to the cost of the service as it is now rendered. The intrinsic escalation in costs that was foreseen by the medical profession prior to the institution of Medicare would be insignificant in comparison to national health insurance.

Lastly, and perhaps most importantly, national health insurance would effectively preclude the medical profession's ever being what it ought to be—permanently.

J. DANIEL BATEMAN, M.D.
Albany

". . . a large group of Americans have come to expect from the bureaucracy the fulfillment they used to seek in religion, family, country and self"

I HAVE BEEN a private-practicing surgeon in Albany, Georgia, for over 15 years. We have seen over many years many significant changes in our health system through increased manpower programs, increased facility construction, increased levels of private health insurance coverage, and creation and extension of several government programs related to health care. I feel that there has been a fuller realization and acknowledgement that this country's health system is indeed superior to any other in the world.

The one thing that I would most regret to see happen is the total socialization of our health care system. I feel that there are many fine points in our present pluralistic type of delivery of health care which must be preserved. I would also be quick to acknowledge that there are certain aspects of our system that need careful scrutiny in order to make the changes necessary to adapt to a changing society.

A major factor in my thinking is to try to limit the further creation of federal bureaucracies. It is my feeling that bureaucracy so compartmentalizes enterprise that even extremely intelligent and dedicated people are prevented from understanding the final purposes of their tasks. They lose a sense of coherence and their duties become too mechanical. In such an environment, motivation withers, talent is smothered and new blood is lost. I am always encouraged to find unusual, courageous and imaginative people who refuse to accept a dull bureaucratic existence. These people are bent on self-development and have learned somewhere along the line that to be happy, they must be effective. In griping about the malaise of bureaucracy, it is my feeling that a large group of Americans have come to expect from the bureaucracy the fulfillment they used to seek in religion, family, country and self. Seemingly, this is an age when people want to have the satisfactions of life provided for them. They look to others rather than to themselves for life's most important rewards.

There are two things most bureaucracies do poorly: 1. Discovering and nurturing extraordinary talent. 2. Conveying untainted information to the top levels of management. In times of stress, these shortcomings are fatal. Sometimes the information that is passed gets tailored to serve the interests of the reporting bureaucrat rather than the whole program. Sometimes this bending of the truth is intentional in order to develop the position of power of some bureaucrat.

The physician who practices medicine gets emotional rewards from giving what he's got beyond any bureaucrat's definition of his job, thus maintaining his mental health.

I feel that any national health program, if it is to benefit rather than harm the American people, must be realistic in its objectives, manageable in its cost to individuals, to families, and to the nation, and as simple as possible in its administration. The present American health care system delivers high quality medical care to more people than any system in any other nation in the history of the world. The objective that we must strive to achieve with a national health program is to assure the benefits of this system to all of our citizens without impairing its quality or inhibiting the creative energy which has developed it. This can best be accomplished by building on demonstrated strength of the present system. Also we must not abandon the expertise of our private health insurance industry.

We do, of course, recognize that there are some weaknesses within the present health care system, but we would hasten to point out the weaknesses, we hope, are in the process of being changed and rectified by our responsive system without the need for a national health insurance program.

Manpower shortages are being overcome; in fact, there will most likely be a surplus of physicians by 1980. Alternative delivery systems are under experimentation. New types of health care providers are being utilized on increasing scale. Greater health education is being carried on by many groups, and new public awareness of the impact of total environment upon health is being aroused.

However, one significant problem which does remain and which appears to us as one of great concern of the public and of the physician, is the one of financial access to care, particularly in view of advanced medical technology and increasing health care cost as well as the state of our economy.

We have all been made aware of individuals or their dependents who have had need of medical care, but who have had inadequate insurance for both basic and catastrophic benefits. It is this type of example which has made us all fear for the financial consequence of illness. Financial hardships, including catastrophes, do occur and provisions must be made for their occurrence, but these occurrences must not be used as the justification for a national program to restructure an otherwise viable, responsive, vital and highly competent pluralistic health

care delivery system as we now have.

Cost controls should be positive in nature. Proper cost controls can be effective in helping to achieve the goal sought by a program of national health insurance. Improper controls will wreak much havoc, create dislocations and aggravate deficiencies that now exist.

Artificial restraints on cost of any service can be accomplished only by reducing either the quality or the quantity of service. This has been the British experience. By arbitrarily limiting their expenditure for health care to 6% of the Gross National Product, they have been forced to continue inadequate hospitals in operation and to deny care by delaying needed but elective surgery for up to two years. Sweden now spends 12% of its Gross National Product on health care and will be spending 15% by mid-1980's. Such cost controls have a negative impact on the whole health care system, for essentially they are based on a denial of care. Improper imposition of utilization review systems that have been attempted on several occasions in this country would be equally negative, since it equates the denial of care.

"There are two things most bureaucracies do poorly: discovering and nurturing extraordinary talent and conveying untainted information to the top levels of management. In times of stress, these shortcomings are fatal"

Positive cost controls can be built into a health insurance program so that they help achieve rather than obstruct the goals of the program. Emphasis on realistic preventive care and an emphasis on ambulatory care rather than hospital care are two such mechanisms.

Another cost control mechanism which should be incorporated in any health program is co-insurance for all except the poor.

Preventive health care, counted by many supporters of national health insurance as achieving a superior state of health, if enacted, is limited in its effectiveness under any health insurance program. National health insurance cannot correct many conditions leading to serious illness and to suggest otherwise amounts to over-promise. For example, how would any physician stop his patient from smoking? What will convince anyone not to overeat or not to pursue an improper diet? Who can be forced to exercise? What will be done to assure adequate housing, clean air, proper working conditions or a healthy environment? What about boredom, indifference, depression and lack of family attachments? Who will stop drug addiction and alcoholism? What about injuries and deaths caused by accidents? There is nothing in national health insurance that will reduce death by homicide, suicide or auto accidents, and these are the leading causes of death among American males under 40.

It must be pointed out that one of the very basic reasons for present concern over the high cost of care can be directly traced to the success in medicine in recent years in its development of new technology. The elderly live longer today because of better medical technology. The seriously ill or injured are often kept alive and eventually returned to normal activities. Organs are transplanted. Today we treat and maintain the chronically ill and the seriously ill and injured beyond what was even imagined 20 years ago. In addition, health facilities are expensive because of the necessity to comply with present statutes and regulations intended to foster quality care. Labor, equipment and supply costs are higher. The increasing minimum wage has already been passed and all of these costs must be borne by hospitals as well as any other employers. Social Security contributions are in line for increases. There are many increasing costs of health care that are out of the sphere of control by the physician.

Universities and medical schools have been able to attract and keep large numbers of physicians by receiving many federal grants which often include the salaries of these physicians. By doing this, these physicians have not left the ivory towers of academics and entered into the mainstream of the delivery of primary health care. These programs and grants warrant review.

Then there is the subject of over-utilization as related to health costs. There is no doubt in my mind that some over-utilization exists both in outpatient and in-hospital facilities. The precipitating factors involve all those in health care: the demands of the patient, the practice patterns of the physician, the ordering of studies and tests that can be used as protection against malpractice litigation and the treatment of the hopelessly ill which involves social, moral and ethical principles which would be too lengthy to discuss here today. How many of you as patients have asked to be allowed to remain in the hospital the extra day beyond when you could have gone home? How many of you have asked the physician to allow a member of your family to remain in the hospital an extra day or two because it would be more convenient for you to transport them home at a later date?

"Artificial restraints on cost of any service can be accomplished only by reducing either the quality or the quantity of service"

There are many of you that have been in a V.A. or other government hospital and remember getting "a pass" to be out over the weekend or several other days while awaiting treatment, but yet you were utilizing a hospital bed. Any utilization review program of hospitals that now exist or may come into being should also be applied to V.A. and other government hospitals. Military medicine, in my opinion, is grossly inefficient in all aspects.

Since I was asked by my colleagues to speak mainly to the issue of cost containment, I have tried to

confine the majority of my remarks to this. In summarizing and in closing, let us consider the following:

1. The pluralistic pattern of the practice of medicine in the United States is superior to any other in the world. Let's preserve the strong points and work together to correct its faults and shortcomings.

2. Let us not create another federal bureaucracy with greater national debt and deficit spending.

3. Let us preserve the private health insurance industry.

4. A health program must be realistic in its objectives, manageable in its costs and simple in administration.

5. Establish positive cost controls and not artificial restraints that limit or reduce the quality and the quantity of service thereby denying care to our people.

6. Establish co-insurance except for the poor.

7. Establish preventive health care.

8. Review utilization of both inpatient and outpatient services in private and government hospitals.

9. Review federal grant activities as related to medical schools.

10. Review the malpractice question.

Lastly, I feel I must caution you against the establishment of any federally controlled and administered national health insurance program. Such a program would result in a decrease in quality care and in availability. I also caution you that no national health insurance program can achieve its goals without the support and commitment of physicians and providers of services. Artificial and unrealistic limitations on reimbursement or interference with the practice of medicine will defeat the purposes of the program. Private enterprise is still the best medicine in a free country.

ADRIAN DAY
Albany

Editor's Note: Mr. Day was born in London, graduated from the London School of Economics and was Director of the Society for Individual Freedom before moving to the U.S. four years ago. He is a reporter for the Albany Herald.

"Don't think that by cooperating with government planners to soften the scheme and improve this regulation or that, you can introduce a universal health insurance scheme that will work. The fault is not in the implementation of the concept; it is in the concept itself"

IT IS AMAZING TO ME, an Englishman, that you are even discussing the introduction of a national health insurance scheme in this country, with examples of the obvious failure of such schemes elsewhere plain to see. To err is human, but to imitate a mistake is folly of the worst order.

The idea of free, universal health care may sound a noble ideal, but its destructive effects both on the individual health consumer and on the nation are clear from an examination of the system in Britain. Though free at the point of consumption, the national health system in Britain costs each individual more in additional taxes and National Health Insurance "contributions" than does private health insurance in America. More than any other single program, it is what has brought Britain to the edge of bankruptcy. It is the largest single budgetary item. And it will destroy the United States as quickly as it has destroyed Britain.

The cost of the scheme has grown faster than anticipated. In 1948, when the scheme was introduced, government planners estimated it would cost about 132 million pounds for the first year, decreasing as untreated cases were dealt with and as the health of the nation improved. The expectations were wildly optimistic and unrealistic. Within two years, the government imposed a ceiling of 400 million pounds a year. By the early 1960s, it was costing over 1,000 pounds annually. Compare this with your own Medicaid, which in 1965 was forecast to cost $3 billion by 1970, but which was already costing $4.1 billion by 1968.

Medicine is like any other product; when it is underpriced, there will be an excess of demand.

The numbers of doctors and their quality decreased rapidly after the introduction of the scheme in Britain and has continued to decrease. There was a ten percent decrease in physicians during the 1950s, despite an increase in population, swelled by immigration from the vanishing empire, and an increase in demand for services. By 1964, there was only one physician to 2,400 people, compared with one doctor to only 540 people here. Because a visit to the doctor is "free," there has been an increase in visits by individual patients.

The standards have declined with many doctors, especially interns in hospitals, not being able to speak or understand the English language, as Britain has been forced to import ill-trained doctors from abroad.

The reasons for the declining numbers is not difficult to discover. A recent survey by the European Economic Community (Common Market) found British doctors to be worst paid of those in all nine EEC countries, at an average of $10,000 a year. No wonder—not to mention the loss of freedom and the red tape doctors have had to deal with—that many of Britain's best doctors left to practice in the U.S. and other countries when the scheme was introduced, and that bright young Britons are entering other fields.

The same thing will happen here. Doctors will depart for other countries, such as Switzerland, or even undeveloped nations, where the pay may be less, but where there are fewer government regulations. Remember: he who pays the piper, plays the tune. When the government pays the cost of health care, it will impose its regulations on how to practice.

For the patient, there are long

waits at the doctor's office or the hospital emergency room, with only a cursory "consultation" at the end by the overworked doctor who does not have the time to examine his patients properly.

As part of the welfare state, providing cradle-to-grave protection, it has devastated individual initiative.

In addition, it has had a horrifying effect on individual freedom, restricting choice of doctors, who are in effect government employees, giving the government access to medical records, and giving the government power to restrict types of medical practice. This is inevitable any time the government controls medicine.

Don't think it won't happen here. Don't think that by cooperating with government planners to soften the scheme and improve this regulation or that, you can introduce a universal health insurance scheme that will work. The fault is not in the implementation of the concept; it is in the concept itself.

It will destroy your health system; it will destroy your economy; and ultimately it will destroy your people and your nation.

CHARLES D. HOLLIS JR., M.D.
Albany

"Government experience with Medicare and Medicaid programs, parcel post delivery and the Social Security system indicates that bureaucracies have increased difficulties of this sort as compared to the private sector"

THE AMERICAN PEOPLE receive the best medical care in the world today. However, some of our people have difficulty obtaining services, the cost to many is burdensome, and catastrophic illness to a few is financially disastrous. The last several national administrations have been committed to compulsory, comprehensive national health insurance, funded by the federal government, as a means of correcting existing problems. Experience in many industrialized nations has demonstrated certain things, however. In a nationalized health care system (a) medical services are made equally available, but frequently less accessible; (b) unit costs rise significantly, with a fall in productivity of the professionals involved, and cost control is achieved only by strict limitation of services rendered; (c) quality of care is compromised.

In introducing a discussion of this sort it might be worthwhile to put things in perspective by correcting some misunderstandings that are commonly held:

1. There is no shortage of physicians or physicians services in this country. There is now one physician for every 540 people, and by 1981 there will be one physician per 420 people.

2. There is no public outcry for comprehensive national health insurance. Eighty-five percent of the people already have some type of health insurance, even though some is not adequate, and 65% of all health care costs are paid by third-party carriers.

3. There is no evidence that changing the funding mechanism alone will correct the problems of access to care. In a survey of underserved people several years ago the following reasons were documented, in order of importance, to explain the failure to obtain services: Patient Education; Lack of Transportation; Accessibility; Availability; Cost (a very small number of patients listed this as a factor).

4. There is no evidence that increased availability of services will improve health, except in the cases of immunization programs, control of blood pressure and perhaps the Pap test for cancer.

5. There is no assurance that a government program can contain costs, improve efficiency, curtail demands for services or eliminate abuses. As a matter of fact, government experience with Medicare and Medicaid programs, parcel post delivery and the Social Security system indicates that bureaucracies have increased difficulties of this sort as compared to the private sector.

6. All of the money attributed to health care costs are not for health care services. Some 40% of the government money goes to nursing home facilities, actually custodial or social services rather than medical services.

"The logical way to proceed is to design a study on a scientific basis to separate demands from the real needs for services and to define the problems in detail. Pilot projects should be organized to study the effects of proposed changes"

7. There is no evidence that a restructured delivery system like an HMO can reduce costs. Overall costs have been reduced by some groups, but analyses reveal that any such reduction is due to utilization control or nondelivery of services, and not to the reduction in unit costs. In some Canadian HMO groups costs have actually gone up. In the Kaiser-Permanente Organization, about 2.2 times as many physicians are required to provide services to its groups of patients as would be required by individual practitioners and the independent groups serving comparable numbers of patients in the same community.

There are significant problems which we should face:

1. Maldistribution of physicians —This maldistribution has probably been funded by the federal government to a large extent. Massive grants to medical schools and teaching centers have concentrated large numbers of physicians around such centers and have financed the education of specialists. The federal government has also perpetuated the discriminatory fee allowances between specialists and general physicians and between urban and rural physicians. Despite many arguments to the contrary, most of the reasons

for maldistribution of physicians is economic. There is also more demand on the physician's time in outlying areas. Around centers, much of the work is done by hospital-paid resident physicians and allied professionals. In rural areas, the general physician is required to do all of the administrative and technical work himself without any compensation. Physicians tend to settle in an environment where work is pleasant, satisfying, and easy, and the pay is good.

2. Overutilization—Without question there is overutilization of many services, particularly sophisticated diagnostic services and hospital treatment. In medical schools, young physicians are not taught a system of providing ambulatory care. In medical teaching there has been little concern for cost-effectiveness of procedures which it utilizes.

3. Malpractice crisis—It has been estimated that as much as 40% of the cost of hospital care is due to the admission of patients to hospitals and ordering of studies to document and justify the work done as protection against malpractice litigation, rather than for the benefit of the patient. A physician is no longer allowed to proceed on the basis of clinical judgment alone, since this tends to be challenged in court.

4. The poorly informed patient—The average person in the United States is a very undisciplined and unknowledgeable consumer of medical services because the medical community, government agencies and civic groups have been remiss in educational activities. The patient is not really taught when he actually needs to consult a doctor, what he can expect from medical treatment and what sorts of problems he can safely take care of himself.

Overtreatment of the hopelessly ill—Incapacitated and senile individuals are routinely and inhumanely kept alive by excessive treatment with antibiotics, parenteral feedings, and life-support devices.

6. The medical education system is unprepared in and disinterested in evolving effective delivery methods for use by young physicians. Professors have had no experience in community practice and are not interested in developing the team approach to medicine which would include physician's assistants, nurses, pharmacists, and technicians. Few, if any, medical schools have complete community practice models in which young physicians can become familiar with delivery methods that would allow maximum physician productivity.

At this point, the question arises as to whether a complete change in funding methods of health insurance is the best way to begin in dealing with the real problems. From our vantage point in Albany, Georgia, many of us feel that the logical way to proceed from this point is as follows:

1. Design a study on a scientific basis to separate demands from the real needs for services and to define the problems in detail.

2. Pilot projects should be organized in about five states to study the effects of proposed changes. There is no great urgency to restructure the entire system immediately.

In states under study, the following features of the plans should be included:

1. Medicare-Medicaid—a. Medicare and Medicaid should be incorporated into the same program; b. insurance policies should be bought from private insurance companies; c. premiums should be shared by the states and federal government, in the case of Medicaid and by the patients and Social Security Administration, in the case of Medicare; d. coverage should be standardized and operation should be regulated by the states; e. coinsurance features should be included in both programs. For Medicaid the patient should be responsible for the first office visit each quarter and for a small daily charge for hospital care. The Medicare patient could have deductibles comparable to those for which he is currently liable; f. to prevent financial hardship, the states should take over payment for all services, once the costs exceed a certain graduated percentage of income.

2. Non-Medicare and Non-Medicaid Patients—a. Catastrophic insurance should be mandated in the states being studied, patterned on the Minnesota plan; b. policies for major medical coverage should be purchased from private companies with specified coverage; c. premiums should be shared by employers and employees where there are more than ten employees; d. for smaller companies and for self-employed people, premiums could be partially covered by tax credits; e. a substantial co-insurance factor should be included, both a front-end deductible and 20% of the total costs; f. the patient, as in Medicare-Medicaid, would be protected against financial ruin by having the states pay costs after personal expenses exceed a graduated percentage of income; g. the federal government should underwrite the costs of these pilot programs in the states on a per capita basis.

The Access-to-Care Problem

1. Institute a massive public education program to teach people when to seek medical care, where to find it, what to expect of the service, and what symptoms should be cared for by themselves. The responsibility for this could be shared by government, schools, health care agencies and organized medicine.

2. In certain remote and underserved areas, provide periodic public transportation to bring patients to existing medical facilities.

3. In a few and unusual remote areas, provide medical access stations, manned by nurses and physician's assistants, but closely supervised by a designated physician. The physician must be held responsible for the quality of care rendered.

4. Eliminate the discriminatory fee schedule between urban and rural physicians and between specialists and general practitioners. With the substantial increase in the numbers of physicians during the next five years, it is quite possible that correcting the economic problems would solve all of the excess problems in outlying areas.

5. Subsidize medical schools to



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WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

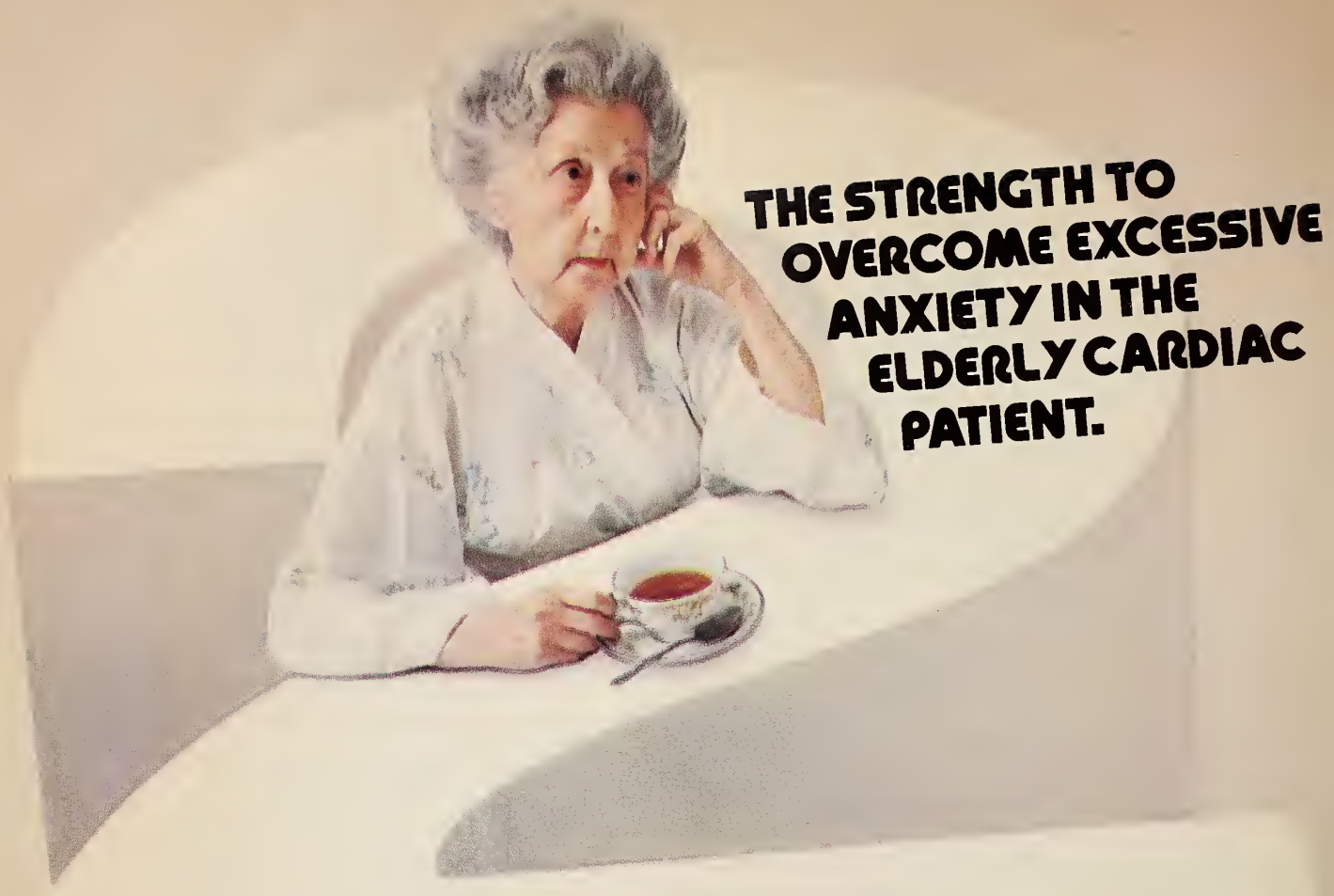
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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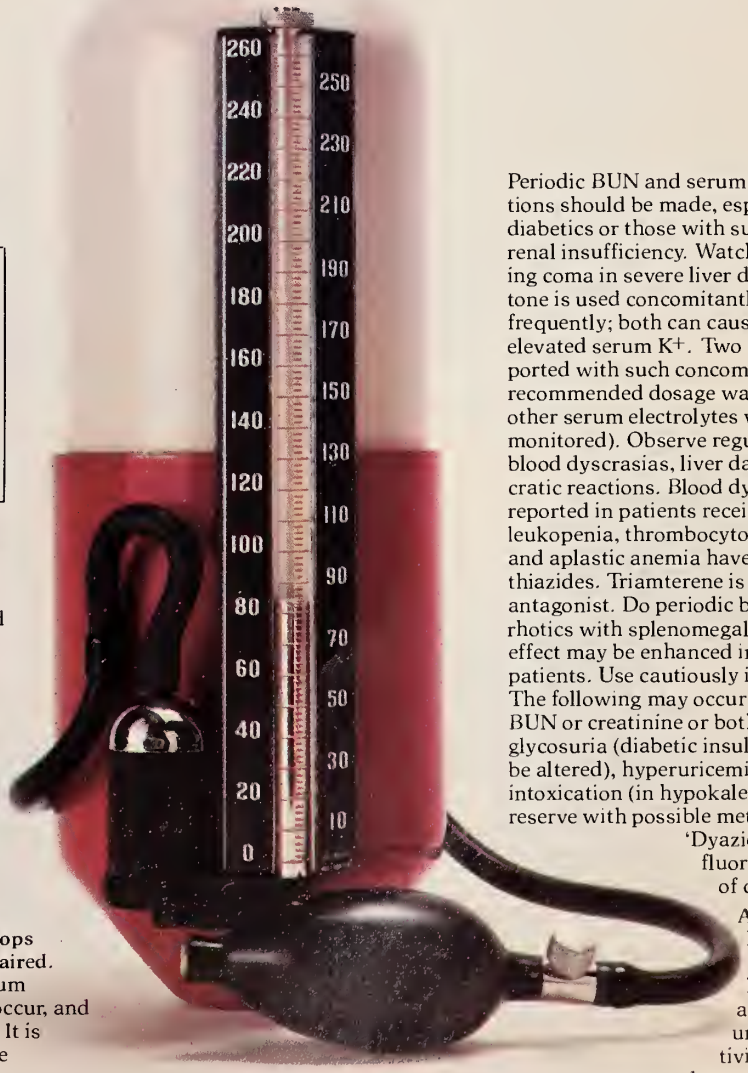
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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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provide community practice models in their medical teaching in a way to increase physician productivity. Provide inducements for medical schools to recruit a certain number of community practitioners with experience in primary care to the faculty.

6. Increase the present trend to utilize community hospitals in medical school training programs, both for students and for residents.

7. Discontinue the present policy of massive federal fundings of fellowships, research grants and professorships, except on the basis of need for training and demonstrated effectiveness of the research workers. This would reduce the number of physicians congregated around medical centers and the problem of large excess of specialists as compared to general physicians.

The Cost-Containment Problem

1. Establish a nationwide cost-effectiveness study for frequently used and very expensive studies. Reimburse only for those services which are found to be cost effective.

2. Offer protection to the hospital and to the doctor against malpractice litigation. Liability should be limited to injury caused by human failure. Economic loss could be funded by mandatory disability insurance policy required of each patient at the time of hospital admission. Incompetence and gross negligence, both in the hospital and by the physician, could best be dealt with in a punitive way by state licensing boards, restricting or removing privileges as an alternative to the awarding of large sums of money in court.

3. Conduct a nationwide study to find where care can be rendered most economically. Unit costs of services vary widely among small offices, large clinics, HMOs, VA hospitals and large municipal hospitals; facilities with lowest costs should be noted and encouraged. Since indications are that unit costs are highest in VA hospitals and in HMOs, the veteran should be taken care of at community hospitals and HMOs should no longer be subsidized.

4. Subsidize the use of ambulatory care by increasing the financial incentives for providing care on this basis.

5. Negotiate reasonable fee schedules for physicians which are consistent throughout the country and allow only for a difference in the cost of doing business. Also, negotiate a per-diem cost for hospitals, separating educational costs from the per-diem allowance for care. Educational costs are excessive in almost all teaching hospitals. Teaching costs should be funded separately.

In summary, it might be appropriate to say:

1. Problems of cost and accessibility in the health care system do exist.

2. The precise need for comprehensive federal health insurance has not been documented. Most people already have some kind of coverage and perhaps it would be more reasonable to explore ways of improving insurance already available.

3. Through Medicare-Medicaid, governments have not demonstrated the capability to effectively operate a health care system. These programs after 12 years are still in a state of near chaos.

4. Scientifically designed studies should be done to define the problems of both cost and access accurately.

5. Pilot projects should be developed in a small number of states to test new approaches, including the combining of Medicare-Medicaid under a plan operated by private insurance companies and regulated by the states and the mandating of catastrophic insurance plans at a state level.

6. Fee discrimination against rural and family physicians should be eliminated.

7. Ambulatory care should be reimbursed at a higher rate.

8. Protection should be offered against the malpractice threat.

9. Medical schools should be encouraged to establish community practice models utilizing the team approach to health care delivery with the help of faculty experienced in this type of practice.

R. LANIER JONES
East Point

"We sense that our patients want to control their own health care expenditures and to retain all of the options that this provides"

I HAVE SERIOUSLY studied the merits and the problems inherent in various proposals for health care delivery systems since 1948, when I was a member of my high school debate team. The national topic for that year was a resolution that there should be a national health insurance system. Later, during eight years of medical school and specialty training, I worked in private hospitals, public charity hospitals and in a VA hospital. For the next four years, I practiced medicine as a member of the U. S. Army. During the last 14 years, I have been a private primary care physician in East Point, Georgia.

This almost 30-year span has been one of rapid and profound change in medicine and in our society. We now have truly effective management for diseases previously untreatable, and some diseases have been virtually eliminated from the earth. Rapid advances in all fields of medicine continue.

I am convinced that persons in the entire health care field share a common desire to see the benefit of good medical treatment available to all of our citizens. You as health care planners and we as physicians should be equally dedicated to this goal. This same 30-year period has seen the development of large group health insurance plans and a rapid spread of both governmental and private health insurance programs. Medicare and Medicaid were initiated. At this time, more than 92% of Americans are covered by some program designed to help alleviate the financial burden imposed by illness. These programs have enabled persons to obtain the best possible

quality medical care through our traditionally free enterprise, private practice system.

Increasingly in recent years, the leaders of various groups in and out of government have proposed sweeping changes that would create a compulsory federal health delivery system which would be financed through the federal power to levy taxes. I strongly feel that such a system is unnecessary and extremely unwise and would eventually result in a general decrease in quality of care rendered. There would be a subtle but pervasive detrimental alteration in the doctor-patient relationship. Few of my patients are wealthy and, since I am an internist, a large number are elderly and have limited incomes which make it necessary for them to spend their medical dollars wisely. Through the years I have discussed the economic realities of obtaining health care with thousands of my patients. My fellow physicians have likewise discussed cost of health care with their patients. In our local medical society meetings, we have shared our observations and have been pleased to note that our patients seem well satisfied with their physicians and the medical care that is provided. There is a striking absence of any real clamor for change in the method of health care delivery. We sense that our patients want to control their own health care expenditures and to retain all of the options that this provides.

"A compulsory program is inconsistent with ideals of individual freedom"

During the summer of 1976, the Southern District of the Medical Association of Atlanta decided to test the premise that our patients were satisfied with the private care that they were receiving. We asked interested physicians in our area to place an opinion poll in their waiting rooms so that their patients could state their opinion on this question: "Should the federal government enact laws to establish a national health system to be financed through added federal taxes?" From our small part of South Fulton County we received in a short period a total of 4,299 replies. Of these, 145 persons replied "yes"; 192 were undecided, and *3,962 replied "no" to the question.* Of the 4,107 who expressed a definite opinion, 3.55% were in favor and *96.45% were opposed.* This overwhelming endorsement of our private practice system has been a source of satisfaction to those of us who provide health care in our area. We recognize the deficiencies inherent in this type of survey; however, we feel strongly that our survey, if done nationwide, would result in millions of signatures of persons opposed to their being included in a compulsory national health system.

We need limited programs to help make good health care available to all of our citizens; however, the preferences of the multitude of persons who do not wish to be included in a national health care delivery system should be respected. A compulsory program is inconsistent with ideals of individual freedom.

We must all work together—physicians, hospital authorities, the health insurance industry, local, state and federal health agencies. Through cooperation, we can devise methods of caring for the health needs of all of our citizens without destroying our private health care system which has provided a quality of medical care which is the best in the world.

JOSEPH A. WILBER, M.D.
Atlanta

"Preventive medicine can be provided by skilled non-physicians at less cost with more effect if the system is organized to meet the characteristics of a well person"

BASED ON 20 YEARS experience in both public health and private practice, I believe we need to revise the delivery system for ambulatory health care. Medicaid and Medicare have shown that "paying the bill" does not improve the health of our citizens and that major revisions must be made in our system of health care if we really wish to prevent illness.

Most plans are designed from the viewpoint and needs of the provider. I would like to propose a plan based on the viewpoint and needs of the patient:

The delivery of health services should be reviewed from the perspective of the individual patient.

The individual perceives of himself as "sick" or "well." The "sick" person has different needs and a different psychology than the "well" person. There should be two plans and two delivery systems; one for the sick and one for the well. These should be closely integrated with easy access from one to the other.

The sick person needs an investigative and individualized approach. He may require a highly skilled diagnostician and therapist. He is motivated by pain, discomfort or worry. He is willing to make sacrifices and use his own resources. He places high priority on getting well.

The well person needs "preventive medicine." Preventive medicine is usually standardized and involves education and motivational techniques. It can be provided by skilled non-physicians (nurses, dietitians, educators) at less cost with more effect, if the system is organized to meet the characteristics of a well person. The well person is often poorly motivated and preventive care probably will have to be entirely public supported in order to reach the majority of the population. It also must be convenient, attractive, and well understood if the person is to cooperate with long-term therapy and changes in lifestyle.

Private medicine, in general, is doing a good job with sick care, but is not as effective in well care (e.g., hypertension, diabetes, obesity, immunizations). Public health, in gen-

eral, is doing a good job with some types of well care in some segments of the population, particularly children and childbearing women of lower economic status.

The delivery of well care when it is confused with sick care is inefficient, neglected, expensive, wasteful and often is based on false expectations (e.g., "an annual physical prevents cancer or heart disease").

Only a few screening and preventive procedures are worthwhile, but these can be identified and targeted to specific segments of the population with the greatest needs.

Only a few of the major health problems of today are preventable or controllable (e.g., high blood pressure, measles, recurrent schizophrenia, early cancer), but these measures are not reaching large segments of the population.

"Multiphasic screening" and "comprehensive health care" must be targeted to specific common health problems with proven control or prevention methods.

In the future, sick care and well care should be provided under the same roof or in close proximity to one another, with close communication and easy access from one to the other. Example: a health department in the community hospital; preventive health outpatient clinics in every community; a rural public health clinic in the same office with the solo general practitioner.

Health education is a vital component of the proposed system. Examples: cigarette-smoking-prevention courses from the first to the twelfth grade in school; breast self-examination classes in high school and available elsewhere regularly in the community; nutrition classes for the obese; diabetes and hypercholesterolemic information available to all regularly in each community.

The dollars saved in preventing strokes, renal failure, diabetic coma and amputations, recurrent schizophrenia and lung cancer should be put into basic medical research on cancer, heart disease and new approaches to influencing life-style.

Before we finance national health insurance, we should proceed now to develop the system, protocols and personnel to provide *well care* in the future as a separately identified component of our current crisis oriented sick care system.

MORTON BOYETTE, M.D.
Albany

"It is difficult to overlook that Lenin stated that socialized medicine is the keystone to a socialized nation"

I HAVE BEEN A PRIVATE practicing physician in Albany, Georgia, for nine years. I do not have a crystal ball to predict how costs for socialized medicine can be contained. However, I can relate some of my observations since entering medicine.

After being made to serve two years in the military, I can say that the military medical care system is to be condemned. To illustrate cost accountability problems in the military, the base hospital couldn't afford simple things, such as enough thermometers, tissues and routine medicines, but upon my arrival on base the hospital commander said, "I have got $30,000 for you to set up your department. If it is not spent in two weeks, the money has to go back to Washington." I ordered the ultimate in equipment. Now the equipment sits there idle due to lack of funding for personnel and general expenses.

The patients eligible for free care when I was in the service were a strange group. They would drive 200 miles to the base to go to the commissary, base exchange and drop by the hospital for a checkup and a prescription. And they demanded what they wanted. They arrived at any hour of the day and night, depending on the convenience for them. Regardless of the physician's assessment, if it didn't suit them, they headed for the hospital commander. Military medicine was downgrading for the doctor and the patient and very inefficient in my experience. Now that several years have passed, the patients I see that are eligible for military care come to me saying how difficult it is to obtain care. Health care was something that was guaranteed to them. In essence *denial of care* is the governmental answer to cost containment for military dependents and retirees. Certainly this is something we could expect in socialized medicine.

I've just learned that health certificates for food handlers are no longer required. The health department doesn't have the funds to provide this service anymore. This certainly saves costs for our taxpayers, but next time you eat out, I hope you don't have the misfortune of contracting tuberculosis.

Competition for the health dollar in socialized medicine will be fierce. If we observe that in England there is one health bureaucrat per 4.8 patients, most of the money will be spent in administering the program. There won't be any money to provide reasonable health care, much less provide money for growth and development and research. Considering my past comments and observations, I can't believe the American people will accept the doling of poor medicine considering the amount of tax money sent to Washington to guarantee good medical care.

For Medicare and/or Medicaid recipients, millions of dollars have been spent by hospitals, doctors and patients for services that were deemed necessary. These expenses were really the obligation of the Medicare-Medicaid programs, but were denied, often for technical reasons, mostly because of shortage of funds. This is definitely a way for government to save money.

Since the progressive federal involvement of health care, the paperwork has exploded. Hiring people to do the paperwork has helped the problem of unemployment, but has also increased costs of medicine. During the past nine years, I believe that minimum wage and Social

Security have been the primary causes of increased medical care costs.

As illustrated, we *can* save money by cost containment. There is denial of care, poor medicine, refusal of payments, confusion by providers and consumers. These are only a few of the means to have money for socialized medicine.

In thinking about a future of socialized medicine, it is difficult to overlook that Lenin stated that socialized medicine is the keystone to a socialized nation. Do you think Americans imagine a future of collective forms tied to socialized medicine? It is difficult to expect the world's most skilled physicians to remain in medicine under a socialized medicine scheme. It is difficult to overlook the bad experience of nations with current socialized medicine. It is difficult to overlook the manner in which current federal health programs are managed. It is difficult to overlook the current trend of deficit spending with lower taxes and greater national debt.

Finally, in thinking about our future, it is difficult to overlook the current trend of voting yourself the right to receive from others.

In a positive way, let's educate our patients on how to utilize the world's best medical care. Let's work toward better distribution of physicians with encouragement to provide the best medicine in an open market of competition with the physician responsible to the patient. Private enterprise is still the best medicine in a free country.

JOSEPH B. BAIRD JR., M.D.
Atlanta

"Specifically appropriate treatment (of mental or emotional illnesses) would increase the effectiveness of health care dollars"

Editor's Note: Dr. Baird represented the Georgia Psychiatric Association.

WE ADVOCATE THE FOLLOWING in regard to national health insurance:

1. Insurance coverage for the diagnosis and treatment of mental illness should be equivalent to coverage for other forms of illness. Studies have demonstrated that 50% of people presenting to physicians with health problems (physical complaints) have some component of mental or emotional illness. Specifically appropriate treatment (intervention) would increase the effectiveness and efficiency of the use of health care dollars. The cost of this specifically appropriate provision of services has been demonstrated under the nervous and mental benefits of Blue Cross/Blue Shield federal employees health benefits program to stabilize at approximately 7% of the total health benefits awarded under that program.

2. Provisions for coverage should include services for children as well as for adults.

3. Coverage should be for problems specified in DSM II and the forthcoming revision, DSM III, of the American Psychiatric Association.

4. Provision of benefits should be based on the need for services which should include services for both diagnosis and treatment. Coverage for a full range of treatment modalities should be provided including custodial care when demonstrated to be necessary on the same basis as coverage for any other chronic illness.

Payment for prescription drugs should be covered. Coverage for programs of prevention should be included.

5. Adequate provisions to maintain confidentiality must be assured.

6. Control of utilization should be achieved by peer review of all modalities of care applied equally to public and private delivery systems.

7. Continued research and investigation of those factors in the development of mental health and the causes of mental illness and in effective methods of primary prevention should be supported.

JOSEPH P. BAILEY JR., M.D.
Augusta

"The American people do not desire more federal control and increased taxes to support programs directed at undermining individualism of spirit or effort"

MEDICAL CARE by physicians and health care services are not the same. These latter services include nursing, nursing homes, ambulances, pharmacy, hospitals, occupational therapy, physical therapy and social service, to mention a few. Medical care is that activity involved in the application of scientific knowledge coupled with the art of medicine developed through the individual relationship of a patient and a physician. However, the physician receives the brunt of criticism concerning costs of all health care services. Clearly, the control of such items as minimum wage, inflation, cost of professional liability insurance, and desires and incentives for more care are outside the control of physicians. All of these facts are emphasized in our state by the 1977 Medicaid expenditures for health services totalling $377,771,000 while physician fee payment totaled $24,832,000, constituting only 7.9% of the total spent.

The spiraling costs of governmental programs in the arena of health care have been emphasized by the horrible state of the budget in the Social Security Administration. To believe that taking on more responsibility for care will meet with improved financial capacity for same is quite unreasonable.

Experimentation in nationalized health care is demonstrated in the British Empire experience. Presently their system is in severe difficulty, as is their country's overall financial status. Are we to believe the nationalized health care system has not in part contributed to England's situation? Certainly, it has led to dis-

couragement for the English patient and physician.

We believe the American free enterprise system constitutes the basis by which our nation has grown to its eminent and superior status. The American people do not desire more federal control and increased taxes to support programs directed at undermining individualism of spirit or effort.

We, therefore, express strong and absolute opposition to the proposal for national health insurance and attempts at increased federal control of our population.

WILLIAM E. MITCHELL JR., M.D.
Atlanta

It is important that first-dollar coverage be discouraged by the elimination of all tax preference and that the government and patient share out-of-pocket expense

PROBLEMS IN HEALTH CARE financing include:

1. Health care costs are increasing too fast.
2. Demand for health care is limitless if near-free at time of consumption.
3. Third-party coverage (government and private) markedly increases utilization without demonstrable increase in quality—a problem magnified by tax preferences for health insurance premiums.
4. Consumers (patients) have inadequate information and incentive to make intelligent, economical choices.
5. Cost reimbursement discourages economy.
6. Disturbing instances of financial disaster, inadequate access and bad care undeniably exist.
7. The pressing demands for *other* uses of public funds (energy research, etc.).

Proposed solutions for a simple, affordable, and workable NHI include:

1. Discourage "first dollar" coverage by eliminating all tax preferences.
2. Immediately increase patient information regarding quality and cost of care (examples were provided).
3. Have government and patient share *out-of-pocket* (not health insurance) costs 50 : 50 up to a specific percent of Net Taxable Income; beyond this "Maximum Risk" or "Catastrophic" level, government would pay 100% of reasonable expenses.
4. Provide partially *refundable* health care vouchers for the poor; all patients, no matter what their income level should have a financial stake in making careful choices about their health care.
5. Finance via general revenues plus heavy taxes on alcohol and tobacco, not via Social Security Tax.
6. Take firm steps to increase quality (e.g. by penalizing sub-standard hospitals and requiring performance-based relicensure).
7. *Avoid* centralized decision-making, more regulations, "cost-caps" and arbitrary resource allocations.
8. Encourage (but do not permanently subsidize) HMO's as an option available to the careful consumer.

E. NOEL PRESTON, M.D.
Atlanta

"As a military physician, I saw countless people demand prescriptions for toothpaste, mouthwash or aspirin so they could get them for free at the base pharmacy"

I DID NOT APPEAR before the HEW panel to speak for or against national health insurance. Secretary Califano stated in the *Federal Register* that the Department of HEW has been directed to introduce a proposal for NHI before Congress. The hearings were to provide input from the public as to *what sort of proposal will be presented.* Thus, arguing against NHI before the panel would be a waste of time. I testified then, as to what I would like to see in the proposal that surely will be submitted to Congress.

Since the health of our children is one of our nation's most important resources, any plan for NHI should provide health care for this important group. Most of the advances in pediatrics that have lowered mortality and medical expenses have been of a preventive nature: immunizations against infectious diseases; Rh globulin to prevent hemolytic disease of the newborn, and soon, vaccines against meningitis and pneumonia. Early treatment of infectious diseases or recognition of congenital defects can save the patient the risk and the third party the expense of surgical treatment of diseased tonsils or dislocated hips. Any health care plan for children, therefore, must be *comprehensive:* it should provide payment for medical as well as surgical treatment, and should provide preventive as well as therapeutic care.

An important part of NHI should be the patient's sharing the cost of the care. People will try to get all they can of whatever is "free," whether they need it or not. As a military physician, I saw countless people demand prescriptions for toothpaste, mouthwash or aspirin so they could get them for free at the base pharmacy. People came to the emergency room at night because it was inconvenient to go to the office during the day. But the taxpayer paid for those "free" prescriptions and "free" after-hour visits, and the same thing will happen under NHI if cost sharing is not made an integral part of the program.

Lastly, there should be a utilization control to prevent abuse of the program, whether by providers or consumers.

I'm not in favor of NHI anymore than anyone else, but if it's coming, I'd like to see it planned and directed by physicians instead of bureaucrats.

JAMES W. BENNETT, M.D.
Augusta

"The option of citizens to seek coverage through other than government-sponsored sources must be preserved"

Editor's Note: Dr. Bennett, Chairman of the Georgia Chapter of the American Academy of Pediatrics, spoke in that group's behalf.

THE ULTIMATE GOAL of those in the private and public sectors of health has been to assure every child access to a single standard of care—that is, a "medical home," regardless of his or her financial status.

We are all aware that this nation's most valuable resource is its children and that the future of the country is dependent upon their good health and welfare. High quality comprehensive health care to all children is essential, while recognizing that socio-economic factors other than medical care, such as income, food, housing, a healthful environment, education and the absence of racial and social discrimination are of great importance in determining their health and welfare.

It is a known fact that the maximum development of adults is largely dependent upon the quality of their health as a child. The problems of children are unique in that as a group they are the most responsive to preventive health services, and access to such care will greatly reduce the incidence of life-long disabling conditions.

Both in terms of delivery and effectiveness, the American health care services are among the highest technological and ethical achievements in human history. However, being products of imperfect people they do fall short of perfection. To make these good things better requires fine tuning and judicious monitoring rather than radical modification. Being aware of the massive problems of excessive overhead and decreasing quality encountered historically with centrally administered and funded health programs, great caution is certainly needed in moving toward any similar approach.

It is strongly urged that funding and administrative mechanisms be adopted which will preserve private health care delivery, extend private insurance coverage and improve necessary public programs. Moreover, new programs should be introduced incrementally and categorically from the catastrophic to the elective within the capacity of the system to respond.

If costs are to be contained within that portion of national income which can reasonably be allocated to health care, it is imperative that aggressive action be taken to reduce the incidence of disease.

Specific Recommendations

I. Development: Any program, including a pediatric component, should be developed with input from the federal and state governments, organized professional groups, consumers and non-government carriers. To ignore input from any of these sectors would seriously cripple the credibility of the plan.

II. Benefits: Comprehensive care for children is needed to include preventive, diagnostic, therapeutic and health education services. Preventive care is particularly important in both the perinatal period and infancy and is necessarily emphasized, for a lack of care at the proper time may have a permanent negative effect on health. The prevention of mental retardation by the early diagnosis of the metabolic errors of hypothyroidism and PKU, in addition to the conquering of almost all of the previously damaging forms of the blood incompatibilities called Rh and ABO, has been a gratifying experience. Virtual elimination of poliomyelitis, diphtheria, and tetanus, and recently, control of leukemia in large numbers of children, point the way to even greater success along the road to better health for all children. We are aware that these accomplishments are offset by the knowledge that economic, geographic and educational barriers to health care still exist for a portion of our child population. It would seem reasonable that a national health program could begin by providing categorical care to discrete target populations who are presently underserved due to barriers which cannot be removed by other mechanisms. High priority should be given to dealing with life-threatening and catastrophic conditions.

III. Payment: A. The option of citizens to seek coverage through other than government-sponsored sources must be preserved. B. Participation should be based upon income and ability to pay. C. Some form of co-insurance should be acceptable. D. Payment should be based primarily on a fee-for-service concept.

IV. Financing: It is strongly urged that any nationally financed component must be financed on an actuarially sound basis (in contrast to the social security "financing from current income" method) with a legal requirement that benefits may not exceed previously assured funding and may not be provided on projected income.

V. Administration: A. The guidelines for eligibility and accountability of both provider and consumer participants in a federally funded program should be federally defined and imposed. The implementing and monitoring should be the responsibility of state governments in concert with state professional associations with consumer representation at the policy level. The administration should reflect the revenue sharing principle of the federal, state and local highway system in dispensing gasoline and road use taxes. B. If financial management becomes uncontrollable, a "public utilities commission" approach may merit consideration. In order to protect the health of the public, evaluation of professional matters must remain with professionally qualified persons.

VI. Quality Control: The Pediatric Panel of the Georgia Medical Care Foundation could be utilized for evaluation of professional matters. Random sampling by computer

selection for peer review may be considered. It would be advisable for these groups to have leverage in enforcement of standards. For example, when continued inadequacies are found, a prescription for remediation and recertification for the provider should be mandated. No major change in certification procedures is needed at this time. The individual states are still and should continue to have the responsibility for determining their own license requirements. Care must be taken that health providers maintain high standards for certification.

VII. Manpower: The distribution problem can be helped by tax incentives to those who are willing to live and work in the underserved areas. Medical teams in mobile units could make regularly scheduled visits to underserved areas.

In conclusion, the Academy would point out that: 1. Childhood presents an opportunity to good health that may never be retrieved again. 2. To take advantage of the opportunity and prevent the undesirable wasteful effects of fragmentation of care, there must be an ongoing relationship with a "medical home." 3. The success of any national health program relies upon the utilization of the experienced pediatrician in both the planning and implementation process.

J. ROBIN DE ANDRADE, M.D.
Atlanta

"Nothing at all has been said about what independence and ability to work means to an individual"

EACH YEAR IN THE United States *new* injury and disease directly affect the lives of millions of people. The disability which results varies in type and extent. The National Safety Council indicates that in 1974, 380,000 people had permanent impairments resulting from accidents.[1] Of the 10,000 children born each year with cerebral palsy, nearly all have disabling impairments;[2, 3] and many of the 617,000 children under age 17 sustaining burns have functional impairment.[4]

The major killing diseases, heart attack, stroke and cancer, result in disability more freqeuntly than death during the first several years after onset. Each year there are 775,000 new heart attacks,[5] 440,000 new strokes[6] and 665,000 new cancers detected.[7] As you know, attempts to treat and cure cancer result frequently in considerable impairment and dysfunction.

Several result studies, including one requested by Congress,[8] indicate the effectiveness of comprehensive medical rehabilitation on increasing independent function.[8, 9] Importantly, they all find similar results. The level of independent function on admission to rehabilitation is about 35% of normal for stroke, spinal cord injury, arthritis and amputation patients combined. At discharge, function has risen to 70% of normal; and at follow-up 2-3 years later, it is up to about 75% of normal.[8, 9]

Return to "work" following comprehensive rehabilitation for severely disabling spinal cord injury is approaching 70% of patients.[10, 11]

Lifetime cost savings in terms of decreased nursing and medical care and increased earnings are now approaching $60,000 per patient following comprehensive rehabilitation for acute spinal cord injury.[10] For the 5,000 Americans with new spinal cord injuries just this year this represents a *national lifetime net savings of 300 million dollars just for careful rehabilitation of one type of catastrophic injury!* Can you imagine what similar cost savings might be for all the major disabling diseases and injuries which occur new each year?

Nothing at all has been said about what independence and ability to work means to an individual who has been severely disabled and to his or her family. The returned opportunity for life, liberty and the pursuit of happiness is priceless.

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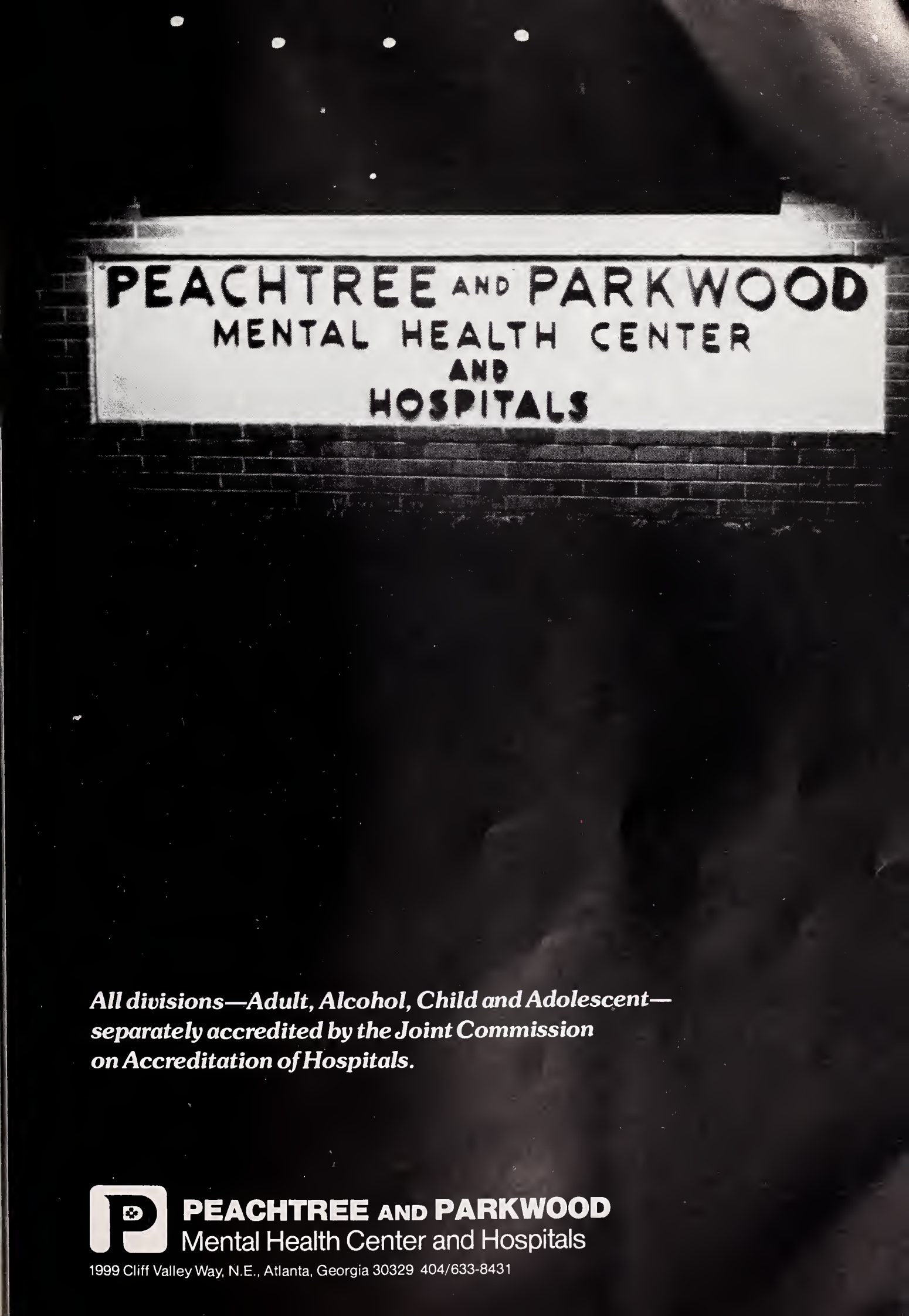
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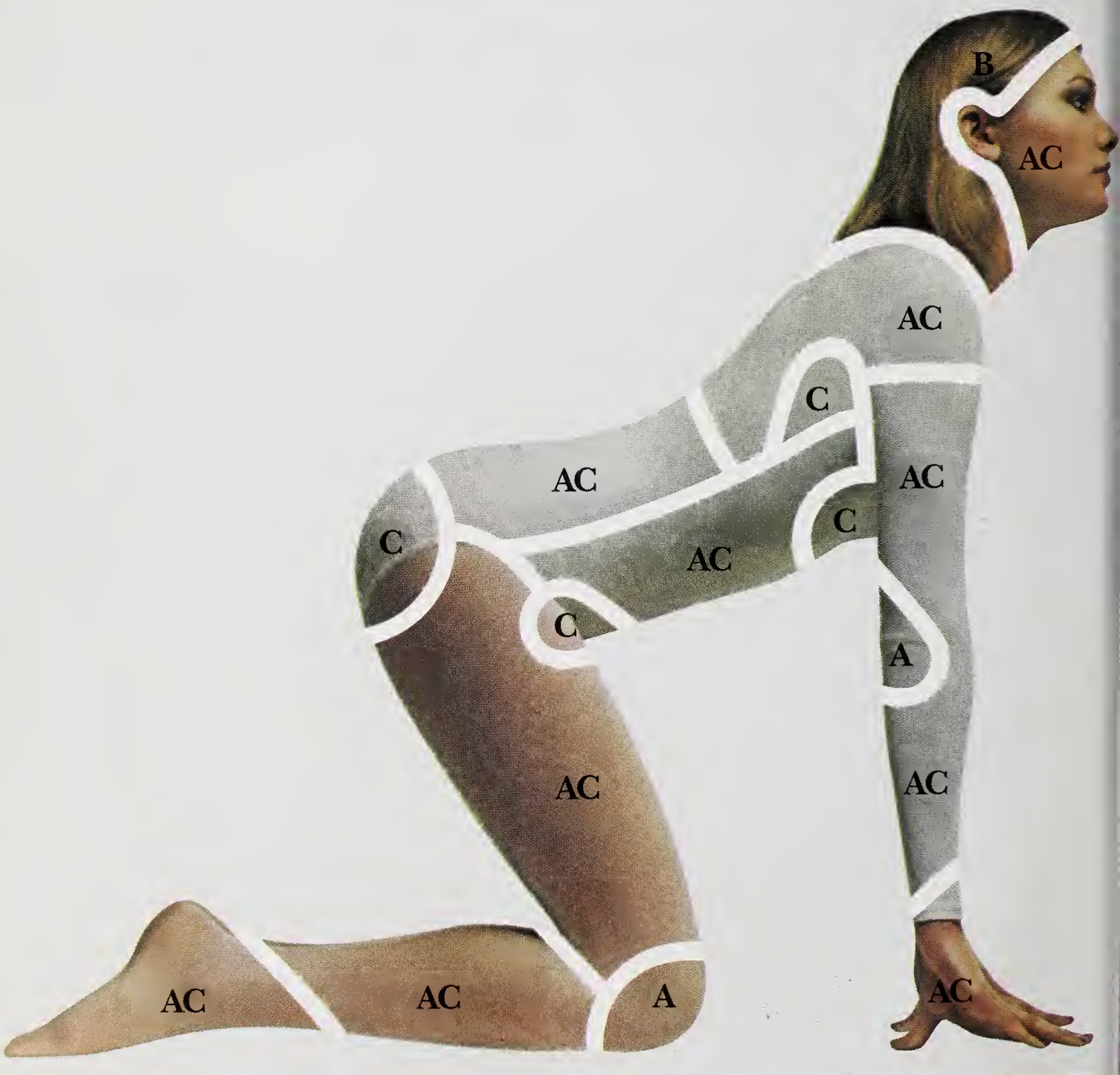
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MAG Loses CHAMPUS Contract

DEPENDENT MEDICAL CARE has traditionally been offered as a portion of the serviceman's compensation. Prior to World War II, nearly all members and families of the Armed Forces lived on or adjacent to a military or naval installation where medical care was easily obtainable.

Prior to 1956, enabling legislation for dependent care was the "Appropriations Act" of 1884, which provided that families be given medical care free of charge "whenever practicable." This permissive concept continued until Congress authorized the "Dependents' Medical Care Act" of 1956, which essentially provided only inpatient care and was limited to spouses and children of active duty service personnel. Outpatient care was authorized only in connection with maternity and treatment of injuries.

To implement this program, the government recognized the need to secure the cooperation of the medical profession. All medical associations were asked to be the "prime contractors" with actual processing of claims to either be processed by the associations or subcontracted to insurance companies. The MAG elected to maintain complete control and has, through the past 21 years, performed all requirements of the program efficiently, in a manner satisfactory to the government and in an attitude of personal concern for physicians and beneficiaries.

During 1976-77, the Department of Defense mandated that all CHAMPUS contracts be opened for competitive, first-price bids. Also during this time, it was determined that emphasis will be placed on utilizing multi-state contracts to permit the national CHAMPUS office to manage the program "more efficiently" by being more centralized.

Effective February 1, 1978, Mutual of Omaha, 3301 Dodge Street, Omaha, Nebraska 68131, will become the CHAMPUS contractor for Georgia. On that date, MAG will become the *last medical association* to lose this activity. With this event, the physicians of Georgia will lose the facility for direct personal contact with a program which expends approximately eight million dollars annually to Georgia physicians.

This is clearly a move away from local control and toward centralization. One has to wonder: If CHAMPUS is headed in this direction, will similar action be taken for other programs, such as Medicare and Medicaid? And worse still, what are the implications in regard to proposed national medical programs?

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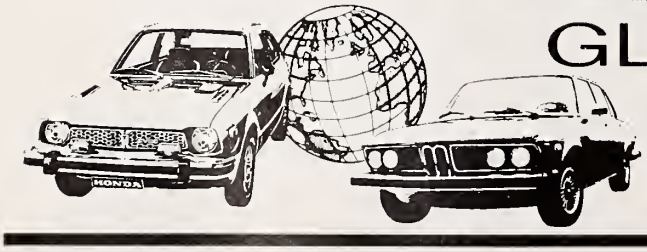
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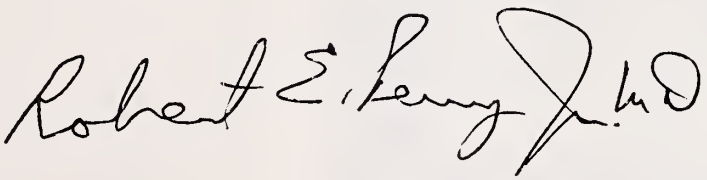


Call for Unity

I WOULD AGAIN like to repeat my call for unity in our profession because it is important for the continued growth and stature of the art and science of medicine.

Having just returned from the 1977 interim session of the AMA in Chicago, I wish I could report to you that the intruding pressure from our federal government had been blunted but, alas, this is not so. If we ever hope to stop this interference, we must unify and remain unified as never before. We have hard decisions to make, but, once made, they must be carried out as one. Splintering into various factions among ourselves and pursuing separate courses of action can only mean one thing and that is the demise of our independence of action for the best care of our patients.

Yours for unity,



Robert E. Perry, Jr., M.D.
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I've told this before . . .

(Editor's note: Children can be amazing in their ability to integrate previous bits of information with new experiences. The results can be quite humorous as illustrated by this story from Dr. Tanner. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30303.)*

Too Much and Not Enough

ALTHOUGH I HAVE TO ADMIT that the children's mother hasn't always agreed with me, I have tried to teach my youngsters to use the proper words for our body parts and functions. I felt it seemed especially strange to hear a physician's child say he wanted to "go pottie" or to "wee wee." It backfired once, however, when it became obvious that in telling all we sometimes don't tell enough!

It occurred when John, the most matter-of-fact child we had, even at three years of age, returned home from a mountain drive with us. We had stopped by the roadside fence to watch a man milk his cow. We said little, just stood watching, and it didn't occur to me to name the cow's parts, but John was especially interested and reluctant to leave.

That he took renewed interest in his milk after that was no surprise. The surprise came two or three days later when, while staring into his glass, he said, "Daddy, who pulled the penises on the cow to get this milk?"

Terrell B. Tanner, M.D., F.A.A.F.P.
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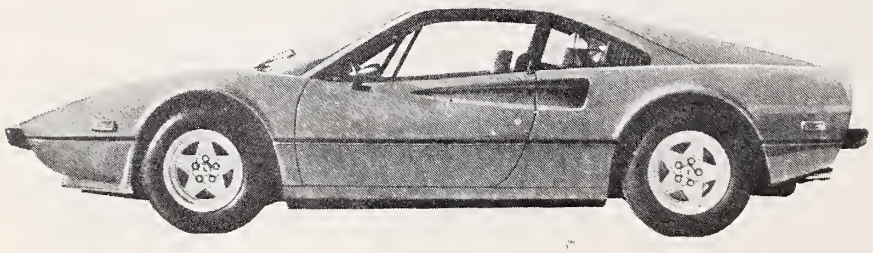
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WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establishe therefore, do not use extensively on pregnant patients, in larg amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptibl organisms (including fungi other than candida). Should superinfe tion due to nonsusceptible organisms occur, administer suitab concomitant antimicrobial therapy; if favorable response is not promp discontinue the preparation until adequate control by other an infectives is effected. If extensive areas are treated or if the occlusiv technique is used, the possibility exists of increased systemic absor tion of the corticosteroid; suitable precautions should be taken. irritation develops, discontinue the product and institute appropriat therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicid are rare. Hypersensitivity to nystatin is extremely uncommon. Hype sensitivity to neomycin has been reported and articles in the curre medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported wi topical corticosteroids either with or without occlusive dressings: bur ing sensations, itching, irritation, dryness, folliculitis, secondary infe tion, skin atrophy, striae, miliaria, hypertrichosis, acneform eruption maceration of the skin, and hypopigmentation. Contact sensitivity to particular dressing material or adhesive may occur occasionally. Ot toxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

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INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions:

1. Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9.5 times greater in users than in nonusers. [ ]

An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. [ ]

In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk.

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion.

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery. [ ]

2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; sudden onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures.

3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. [ ]

One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented.

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

4. HEPATIC ADENOMA. Benign hepatic adenomas appear to be associated with the use of oral contraceptives. Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. [ ]

5. USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes.

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births.

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend 3 months.

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. GALLBLADDER DISEASE. Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years.

7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives.

8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives.

9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause.

10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease.

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods.

11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies. [ ]

12. BREAST FEEDING. Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned.

PRECAUTIONS: General 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered.

d. Decreased pregnanediol excretion.

e. Reduced response to metyrapone test.

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS):

Thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

Mesenteric thrombosis; benign hepatomas; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related:

Nausea, usually the most common adverse experience; vomiting reaction, occurring in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally; gastrointestinal symptoms (such as abdominal cramps and bloating); breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma which may persist; breast changes: tenderness, enlargement and secretion; change in weight (increase or decrease); change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis.

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted.

Premenstrual-like syndrome; intolerance to contact lenses; change in corneal curvature (steepening); cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria; impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females. [ ]

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A Report of the Colon and Rectal Task Force, Georgia Division of American Cancer Society

CHARLES R. UNDERWOOD, M.D., *Marietta**

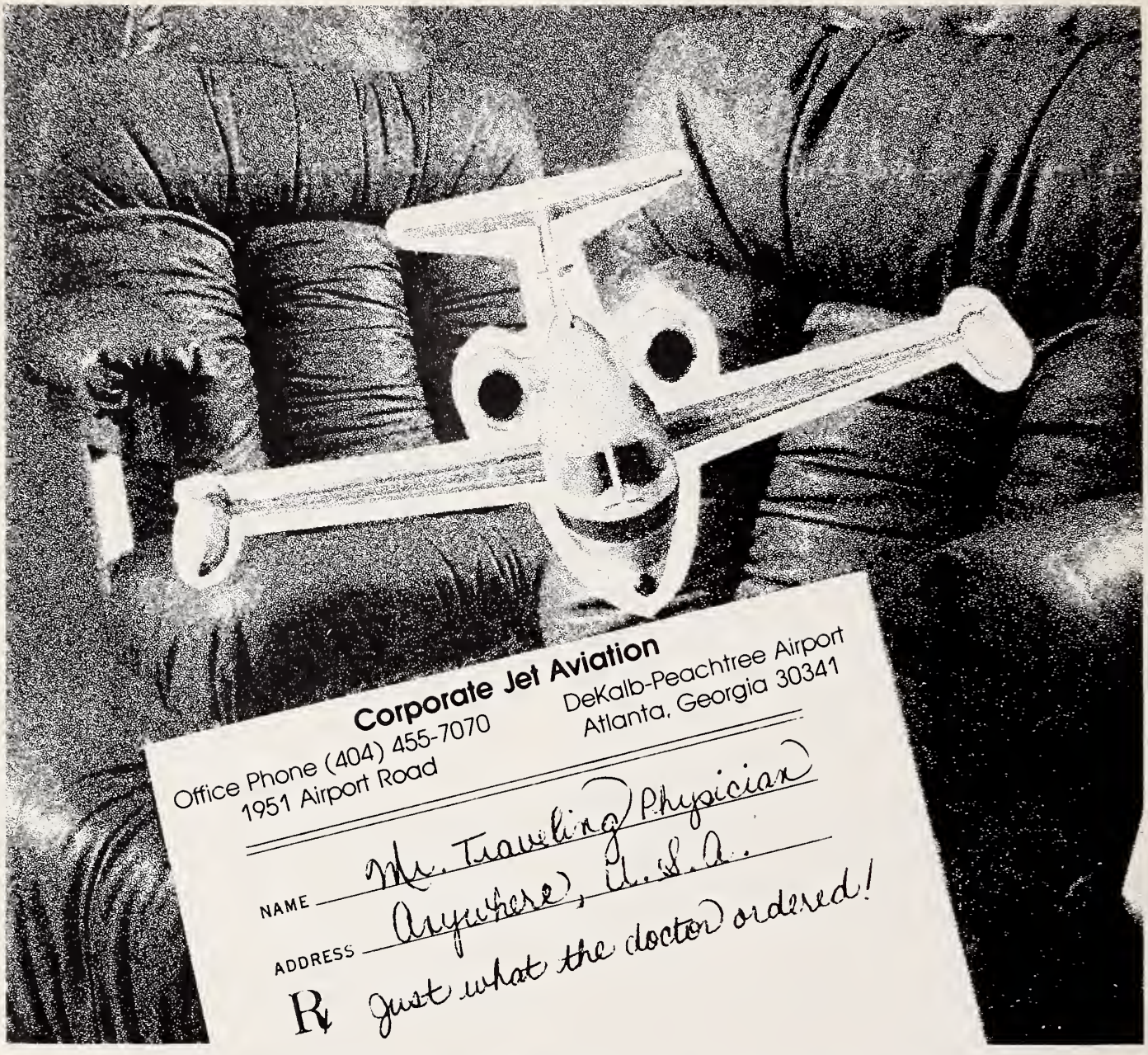
THE 1977-1978 SITE EMPHASIS of the Georgia Division of the ACS places colon and rectal cancer in the number-two position following lung cancer. For the past few months, a task force assigned to evaluate this problem has been actively engaged in an evaluation of several aspects of the colon and rectal cancer problem. The final conclusions of this task force have recently been presented and approved by the Board of Directors.

Although the annual procto-sigmoidoscopic examination is a desirable objective and should be part of every "complete medical evaluation," it is not felt to be feasible as applied to the entire population and therefore will in the future be recommended only for the patient thought to be "at risk." This would include anyone having signs or symptoms of colonic disease and those individuals with a family history of such disease. The Committee carefully evaluated many aspects of the several methods whereby occult blood can be detected in the stool and particularly the advantage of such determination as a screening tool. It was our final recommendation that the Hemoccult test is of such a degree of reliability that it can be recommended as such in the future. The basic recommendation relating to the use of the Hemoccult test is as follows: No special diet will be utilized for the first screening; a single positive on any of the three initial slides will result in a retesting with diet; a positive slide on retesting will be reported as a "positive to the patient" and physician referral recommended; a negative slide on retesting will result in a recommendation for retesting with special diet in three months. While realizing the difficulties associated with such a program and the hazards of false-negative and false-positive reports, it is the feeling of the Committee that if this protocol is followed, it will result in a significant improvement in early diagnosis of colon and rectal cancer.

This screening program will be instituted promptly and information relating to it can be obtained from any division of the American Cancer Society. An aggressive public and professional education program is now underway and should make the program clearer and more effective as time passes. Obviously, the success of such a program is dependent upon physician cooperation, and it is our hope that past prejudices concerning such a program can be minimized in an effort to improve the early diagnosis and subsequent improved cure rate that can be realized from such a program.

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* Chairman, Colon-Rectal Task Force, Georgia Division, American Cancer Society. Dr. Underwood's address is 641 Church St., Marietta, Ga. 30080. Prepared at the request of the American Cancer Society, Georgia Division. Others wishing to contribute papers to this department are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.



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Civil Litigation: Physicians' Rights and Obligations in Producing Patient Records for Discovery Purposes

RICHARD H. VINCENT, *Atlanta**

DOCTORS ARE FREQUENTLY requested to furnish copies of their patients' medical records to parties who are involved in civil litigation with those patients. Although in many instances this information is furnished willingly and informally by the doctor, it is sometimes helpful for the doctor to know the exact limits of his rights and obligations with respect to various aspects of this procedure when the request is not accompanied by a written authorization signed by the patient.

No Physician-Patient Privilege in Georgia

Many states have provided, as a matter of public policy, that communications between a patient and physician are confidential and are not, therefore, subject to disclosure without the consent of the patient.[1] In Georgia, this privilege is afforded to communications between a psychiatrist and his patient,[2] but there is no general privilege with respect to most communications between a physician and his patient.[3]

Statutory Provisions for Discovery of Patient Records

In the absence of such privilege, general statutory provisions dealing with production of documents for inspection and copying, etc. would apply. *Georgia Code Ann.* §81A-134(c) deals with this question as it relates to doctors who are not parties to the litigation itself; it requires the party seeking the production of the documents to proceed by taking the deposition of the doctor either on oral examination or upon submission of written interrogatories.[4] Both methods involve the doctor answering questions under oath; in oral examination the format is the traditional question and answer approach, usually involving the attorney for the party seeking the information; in written interrogatories the questions are furnished in writing to the doctor in advance of the deposition and are then read by the court reporter from the previously prepared list. In both cases, the doctor answers orally and is asked to supply a copy of the material sought to be produced.

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* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner in the firm of Powell, Goldstein, Frazer & Murphy, 11th Floor, C & S Bank Building, Atlanta, Ga. 30303, General Counsel to the Association.

Statutory Provisions Affording Protection for the Doctor

There are, of course, situations where a doctor cannot comply, or desires not to comply, with the terms of a request to produce patient records. If the doctor has been subpoenaed to appear at the deposition with his records, he has two primary means for seeking protection from the court:

1. The doctor may, under *Georgia Code Ann.* §81A-134(c) and 126(c) move the court for a protective order on such grounds as annoyance, embarrassment, oppression, or undue burden or expense. Upon a showing of good cause, the court may grant such relief from the subpoena as it deems appropriate.[5]

2. If the doctor does not contest the subpoena requiring him to appear at the deposition, but does not wish to produce the documents requested, he may wish to utilize *Ga. Code Ann.,* §81A-145. Under that section, within certain time limits from his receipt of the subpoena, he may serve upon the attorney designated in the subpoena written objection to the inspection of, or copying of, any or all of the designated materials. If this objection is made, the doctor must still *appear* as required by the subpoena, but the party serving the subpoena shall not be entitled to inspect and copy the materials unless he first obtains an order from the court issuing the subpoena. The burden remains with the party seeking production of the documents to file such a motion and to demonstrate that he is entitled to inspect, copy, etc.

If the doctor has not been subpoenaed to attend the deposition, but has merely received a notice of the taking of his deposition, his most effective form of "protection" may be simply to ignore the notice; Georgia law provides no sanction against a person (not a party to the litigation) who refuses to appear at the request of a party, unless he has been subpoenaed. Moreover, it would appear that even if an unsubpoenaed doctor voluntarily appears to give testimony, he could elect at any time to terminate the deposition by leaving. Alternatively, if he merely objects to answering some of the questions propounded:

(a) if he is responding to oral questions, he may refuse to answer a particular question; or

(b) if he is responding to written interrogatories, he may, under *Ga. Code Ann.,* §81A-134(c) move for a protective order as described above.

Possible Benefit to Doctor Who Insists on Strict Compliance

Even if the doctor has no objection to furnishing the requested material, it is better practice to insist on strict compliance with *Ga. Code Ann.* §81A-134(c) so that parties to the litigation will receive notice of the request for documents. In those cases where the patient is a party to the case, the patient will have an opportunity to object if he so chooses. His failure to object may later be construed as a consent to have the information furnished.[6]

NOTES

1. See generally 81 *Am. Jur.* 2d, Witnesses, §230.
2. *Ga. Code Ann.* §38-418 (1974), 1959 *Ga. Laws,* 190.
3. *Elliott v. Georgia Power Co.,* 58 *Ga. App.* 151 at 154, 197 *S.E.* 914 (1938).
4. This section is frequently cited as authority for obtaining copies of medical records merely by serving interrogatories directly upon the doctor, as opposed to giving notice to all parties of the taking of his deposition on oral examination or upon written interrogatories. The Georgia Civil Practice Act, however, contains no provision for submission of interrogatories to non-parties, except through the device of a deposition upon written interrogatories. The correct meaning would be clearer if the words "or oral examination" were read "*on* oral examination," and it appears likely that a typographical error has been included in this statute.
5. See *Ga. Code Ann.,* §81A-126(c) for examples of the type of relief the court may grant.
6. Even though there is authority for the proposition that, since there is no general medical privilege in Georgia, there can be no damage to a patient if his doctor discloses his records [*Collins v. Howard,* 156 *F.Supp.* 322 (S.D. Ga. 1957)] the trend of the law is toward the developing rights of privacy, and we may expect to see additional developments indicating possible liability for unauthorized disclosures of medical records.

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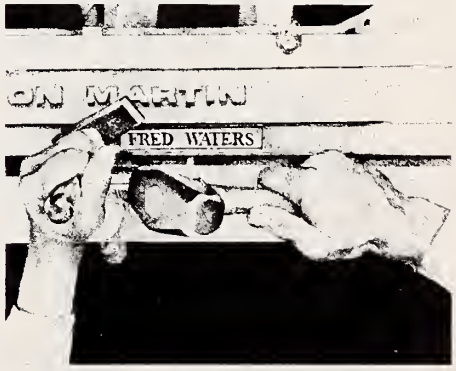
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PERSONALS

Second District

Charles E. Zimmerman, M.D., of Tifton, was named a fellow of the American Academy of Family Physicians.

Fourth District

Decatur physicians **Charles Allard, M.D.,** and **L. C. Buchanan, M.D.,** volunteered their time and services in November to perform physical examinations for inmates of the DeKalb County jail.

Fifth District

Orthopedic surgeon **William C. Collins, M.D.,** of Atlanta, has been nominated without opposition to be president-elect of the Medical Association of Atlanta.

Mark M. Lindsey, M.D., of Atlanta, was elected as chairman of MAG's Interspecialty Council in October.

Sixth District

Senen J. Encinas, M.D., of Forsyth, was named a fellow of the American Academy of Family Physicians.

Seventh District

Family planning physician **Benjamin S. Anderson, M.D.,** was presented a certificate of appreciation by the district director of health in the Coosa Valley Health District for his 11 years of service for the Polk County Health Department.

Joseph Bishop, M.D., of Calhoun, was named a fellow of the American Academy of Family Physicians.

Richard Cohen, M.D., is secretary of ARC's Human Services Planning Advisory Council. Dr. Cohen is Cobb County Medical Society's representative to the Council.

Kennesaw physician **Stephen C. May, Jr.,** has been installed as president of the Georgia Academy of Family Physicians. Dr. May is chief of general practice at Kennestone Hospital and past president of the Cobb County Medical Society.

Tenth District

John J. Allen, M.D., of Athens, has been named a fellow of the American Academy of Family Physicians.

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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

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Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

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Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
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MAG Scientific Assembly—Best Ever

Eight hundred and ninety-one people registered for the 1977 Scientific Assembly held November 17-20 at the Omni International Hotel in Atlanta, up 373 from last year's registration.

The Assembly, held annually, was organized to provide a source of high-quality continuing medical education to physicians and other health professionals and to serve as a forum for the state specialty societies to present their own scientific programs.

Eighteen specialty societies participated in this year's Assembly, with the Georgia Society of Pathologists having the largest number (158) in attendance. The American College of Physicians, Georgia chapter, and the American College of Surgeons, Georgia chapter, also had in excess of 100 in attendance.

Dr. G. Timothy Johnson, columnist and host of the "House Call" TV series, delivered the Abner W. Calhoun lecture at the luncheon sponsored by MAG on Friday. The subject of Dr. Johnson's lecture, "Health Education for the Public—Organized Medicine's Responsibility," drew many questions and comments from the luncheon guests during the question and answer session that followed the formal speech.

The Georgia Society of Internal Medicine also sponsored a luncheon on Saturday, November 19, at 12:30 p.m. The speaker for the luncheon was Duncan Neuhauser, Ph.D., from the Harvard School of Public Health. Dr. Neuhauser spoke on "Cost-Effective Clinical Decision Making."

Dr. Nahai Receives ACS Award

FOAD NAHAI, M.D., resident in plastic and reconstructive surgery at Emory University, was presented a $200 award by the American College of Surgeons, Georgia chapter, at the recent Scientific Assembly of the Medical Association of Georgia for his paper on "Free Transfer and Replantation of Composite Tissue by Microvascular Techniques."

The competition, sponsored by the College, was open to surgical residents from various surgical training programs within the state. Other residents whose papers were selected for reading in the competition included James W. Isaacs, M.D., general surgical resident in the Emory program, for his paper entitled "Parenteral Nutrition of Adults with a 900 Milliosmolar Solution via Peripheral Veins"; Ronald Kaplan, M.D., general surgical resident in the Piedmont program, for his paper entitled "Bacteroides Bacteremia," and Millard Ross, resident in general surgery in the Georgia Baptist Hospital program, for his paper entitled "Radioactive Scans to Aid in the Diagnosis of Meckel's Diverticulum."



Carter Smith Jr., M.D., chairman of the MAG Committee on Scientific Assembly, introduces guest speaker at MAG luncheon.



G. Timothy Johnson, M.D., guest speaker at MAG luncheon, delivers Calhoun lecture.



Mrs. Mary Beth Busbee (wife of Gov. George Busbee) was one of the special guests of honor attending the MAG luncheon.

"Health Education for the Public—Organized Medicine's Responsibility"

Dr. Timothy Johnson Delivers Calhoun Lecture

THE GREATEST PROBLEM in physician-patient relationships today is the over-expectancy of the patient as to what medicine can do, according to Dr. G. Timothy Johnson, noted columnist and host of the nationally televised "House Call" TV series.

In Atlanta to speak at the Calhoun Lecture sponsored by the MAG Scientific Assembly, Dr. Johnson said, in an interview November 17, that the visual media, through dramatizations such as "Marcus Welby," has taught the public to expect too much from medicine.

"Physicians know that 90% of medicine is a gray area, not black and white," he said. "The public though, as it stands now, believes that medicine can produce miracles, and when those miracles are not forthcoming, then (it feels) either somebody committed malpractice or didn't know what he or she was doing."

Dr. Johnson, who spoke on "Health Education for the Public—Organized Medicine's Responsibility," said it is the responsibility of public health educators, as well as physicians, to re-educate the public about medicine and its limitations.

Another responsibility of public health educators and physicians is to help lay persons sort out the avalanche of health information now being heaped upon them.

"I believe the public no longer lacks for health information," Dr. Johnson said. "Public educators need to help people sort out the mounds of information they receive from various sources and help them make decisions about what is sound advice and what is hogwash."

Response to such help can be overwhelming. Although there is only time to respond to four to seven phone calls in the five minutes allotted on Dr. Johnson's TV show for questions from the audience, the station receives, in that five minutes, an average of 4,000 phone calls from people with questions on health and medicine.

Correlating with this increased concern about health is an increased concern about health care costs and because of this, Dr. Johnson feels that some form of cost control for health care will be inevitable. He personally supports the idea of a cost control program, although not one that is controlled by the government.

Dr. Johnson is in agreement with that segment of the public that is beginning to view medical care as a basic right, in much the same way that it views a good education as a basic right.

"By basic right, I don't mean that anyone should be able to go out and get a nose job just because he or she wants one," he said. "But everyone should have a right to such basic medical care such as, for example, immunizations."

Dr. Johnson is currently serving as Director of Lay Health Information and as a clinical instructor in medicine at Harvard Medical School, as editor of *The Harvard Medical School Health Letter* (a newsletter for lay persons with a circulation of 50,000), and as a clinical associate in medicine at Massachusetts General Hospital.

The host and writer of "Update on Health" (TV syndicated health programs) and the physician for "Good Morning America," Dr. Johnson resides with his wife, Nancy Ann, and their two children in Topsfield, Massachusetts.

Editor's note: The following is a major portion of Dr. Johnson's speech delivered November 18, 1977.

HAVING NOW EXPLORED my own personal experience with the media in terms of public health education—and having briefly sketched a portrait of the public's attitude toward organized medicine—I am willing to ask these hard questions: 1) Does organized medicine have a responsibility to public health education? 2) If it does, is organized medicine appropriately suited to meet it?

As to the first question, the initial answer today by most would be "yes." But there are those who cogently and intelligently argue that doctors, either individually or collectively, cannot and should not be all things to all people. Some of you may recall Franz Inglefinger's editorial in which he suggested that doctors are trained to diagnose and treat illness and that it should be the primary task of others to counsel, educate, motivate. etc. I personally think there is some truth to that observation—at least to the degree that we should not dilute the training of American physicians in general to the point where there are no longer enough physicians equipped to handle the problems of the seriously ill. But I also think it is short-sighted to think that physicians can escape at least an indirect responsibility to be concerned about and influence the course and content of public health information efforts.

For example, for many years the dictum that everyone should have a head-to-toe annual check-up went

pretty much unchallenged. Today, as you know, the pendulum has swung in the opposite direction to the point where some are now saying that such routine check-ups are at best wasteful of time and money and at worst—particularly if involving extensive screening tests—dangerous and unnecessary. The result, in my observations, is a public quite confused about what they should do in terms of personal health maintenance. When they buy a car, the program of maintenance is spelled out in no uncertain terms—to the month. But there is no such agreed upon plan for the care of the human body or psyche. And I submit that this is too complex and subtle a matter to be left entirely to public health informers without some honest and direct input from the practicing physician community that is willing to tell the truth, when known, about the benefits versus the risks of various health care practices.

Furthermore, I think an obvious avoidance of the arena of public health information by physicians will lead to further erosion of the interface between the public and physicians. And that erosion will be both in the areas of attitude and information.

If physicians do not speak to public concerns, the public might conclude that physicians do not really care about public health and the prevention of disease but only about reaping the benefits of sickness. And if physicians are unwilling to speak out about matters that clearly affect public health attitudes—such as cancer treatment and laetrile—we begin to pay the price for allowing other, more aggressive spokesmen to take over the stage.

So, my own personal answer to the posed question is "Yes." I think it is both legitimate and necessary for physicians, at least some physicians to some degree, to become involved with the media in terms of public health information. It goes without saying, in terms of my previous observations, that such involvement should be within certain guidelines of good taste and professional ethics.

We now come to what I consider to be the much more difficult question: *Is organized medicine the best vehicle for physician involvement in public health information endeavors?*

Obviously, organized medicine is, in general, financially and administratively better able to address itself to public health measures than most individual physicians. But whether organized medicine should do this *as organized medicine* is another question, I think. *To put it bluntly,* I wonder if the public will listen to and accept the informational advice of organized medicine —be it from the AMA or a state or county medical society—given the suspicion on the part of the general public toward any official group, government or otherwise. For sure, any such advice that appears to be self-serving will be held in suspicion. And that's a continuing problem, because much of our advice must honestly still involve recommendations for involvement with physicians.

I'll give you this example. The MMS (Massachusetts Medical Society) has conceived a sound and well-presented campaign to improve personal health habits in the areas of smoking, drinking, exercise and eating. It is entitled, "Avoid Self-Pollution—It's in Your Hands." It is, as I say, cleverly presented and has been avidly supported by physicians and other official health groups in the state of Massachusetts. And I personally think it has been worth doing. But I have also heard a considerable amount of "grumbling" from the average citizen that the effort is a "cover-up" for other ways in which the Medical Society, they think, ignores them and their health care needs. In short, I am beginning to wonder if any official group today, including organized medicine, can ever really win with the public. And while we may grumble about the emotional illogic of all this, if our goal is to communicate, we may have to accept the reality of this current climate.

Rather, the best approach for organized medicine may be to support those individual or non-official collective efforts that are willing and able to attempt to inform the public. This support could come in ways both financial and administrative, i.e., research, resource persons, visual materials, etc. It could also come in the form of simple encouragement to those individuals who are willing to give it a try.

To be more specific, I will close with the following two examples of what I think are possible and legitimate contributions to public health information by organized medicine:

1) As I have described earlier, the structure of the public media in most cases is that of non-medically trained persons assigned to the task of sorting out and reporting health information. In many of these cases, the stations or papers involved—or the individual reporters and producers themselves—will welcome help if they are convinced it will be honest and not self-serving. I would suggest that you consider offering such help in your respective communities by being willing to research a given topic, or provide visuals from your resources or actually provide on camera or on radio physicians from your society. It goes without saying that it is critically important to identify those physicians who are willing and capable of doing this in a non-self-serving way. And you must be willing to back up these people when they may have to say or do some things that will alienate parts of your medical community. For example, if such a physician recognizes that some unnecessary surgery exists but then goes on to put the matter in perspective, don't jump all over that physician because he was honest.

2) I would strongly urge that if you have not done so already, appoint a public relations committee—but call it something else given the bad name that PR has in our society—that is willing to become skilled at working with the media in arranging (that's a better word than "staging") sources of medical information that the media will consider newsworthy and therefore cover.

For example, if the medical society, through some official spokesman, releases an official statement about the dangers of laetrile treatment, then it will, I think, be generally dismissed by the public as self-serving. But if the society is willing to identify a patient who has personally suffered because of laetrile treatment and arrange for that person to tell his or her story, the media will be attracted and the public will listen.

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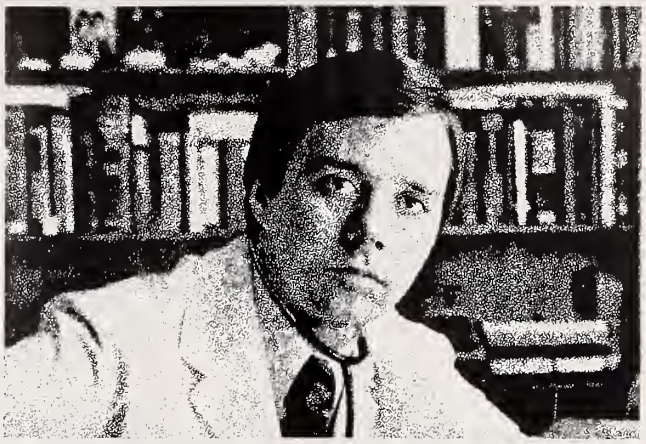
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Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

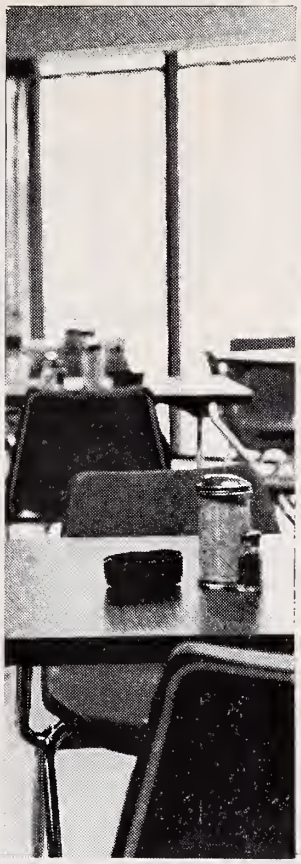
Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

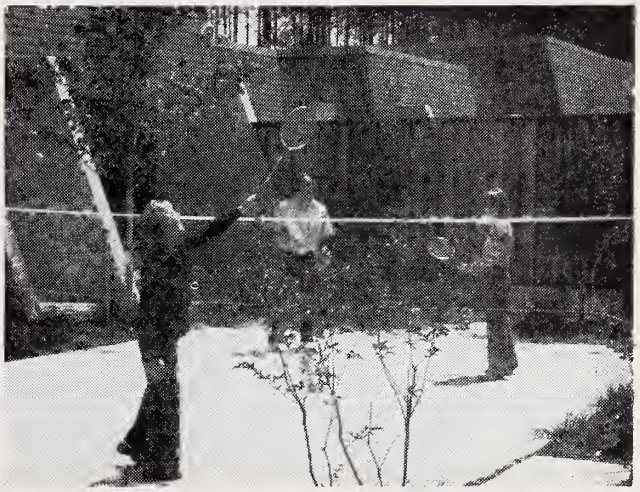
For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200





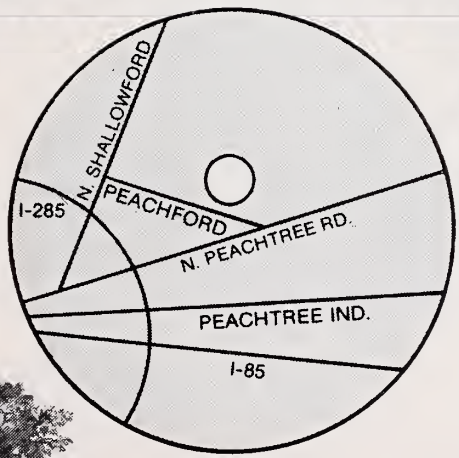








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JOURNAL
of the medical association of
georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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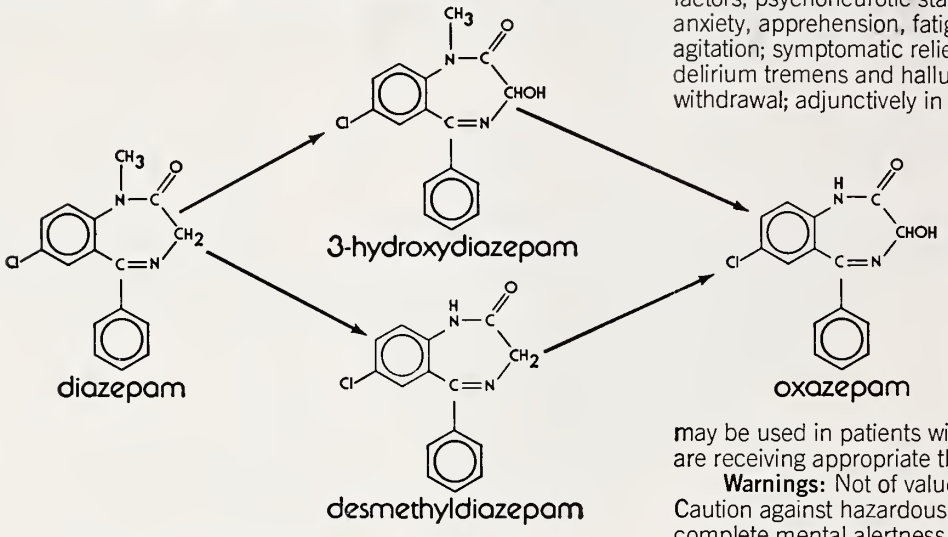
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MAG ANNUAL SESSION
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Official Program Inside





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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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Medical Meeting Calendar

MARCH

2, 9, 16, 23, 30—*Atlanta;* **SEMINAR IN DREAMS;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., N.E., Atlanta 30326.

5-8—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Wynnell S. Hopkins, 875 West Peachtree St., N.E., Atlanta 30309.

7—*Fort Oglethorpe;* **METABOLIC DISEASES;** Category 1 Credit; Contact: Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe 30741.

7, 14, 21, 28—*Atlanta;* **SEMINAR IN PSYCHOTHERAPY;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., N.E., Atlanta 30326.

9-11—*Atlanta;* **SOUTHEASTERN REGIONAL CONFERENCE ON CHILD PROTECTION;** Contact: Kathern Bond, The American Humane Association, P. O. Box 2788, Denver, CO 80201.

16-17—*Atlanta;* **DRUG ABUSE IN TODAY'S ADOLESCENTS;** Category 1 Credit; Contact: Registrar—14th Floor, Pennsylvania Hospital, Conference Center, 360 Lexington Ave., New York, NY 10017.

17-18—*Charleston, SC;* **UROLOGIC PEARLS FOR THE FAMILY PHYSICIAN;** Category 1 Credit; Contact: Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29401.

17-19—*Kiawah Island, SC;* **SOUTH CAROLINA REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Roy A. Howell Jr., M.D., F.A.C.P., 210 Market St., Bennettsville, SC 29512.

21-23—*Greenville, SC;* **GREENVILLE POSTGRADUATE SEMINAR;** Category 1 Credit; Contact: Greenville Postgraduate Seminar, 101 E. North St., Greenville, SC 29601.

23-25—*Gainesville, FL;* **9TH ANNUAL TOPICS IN INTERNAL MEDICINE;** Category 1 Credit; Contact: Bill Rockwood, Coordinator, Division of Continuing Medical Education, University of Florida, Box J-233, J. H. Miller Health Center, Gainesville, FL 32610.

27-30—*Atlanta;* **INDEPENDENCE WITH DIGNITY: ACTION '78—SECOND NATIONAL CONFERENCE ON AGING AND BLINDNESS;** Contact: Dorothy Demby, American Foundation for the Blind, 15 W. 16th St., New York, NY 10011.

29-31—*Atlanta;* **STROKE SEMINAR: CURRENT TRENDS IN COMPREHENSIVE STROKE CARE;** Category 1 Credit; Contact: Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312.

29-31—*Atlanta;* **AMERICAN SOCIETY FOR CLINICAL PHARMACOLOGY AND THERAPEUTICS;** Contact: Mrs. E. Galasso, Executive Secretary, 1718 Gallagher Rd., Norristown, PA 19401.

29-April 1—*Atlanta;* **PERSPECTIVES IN SURGERY: LIVER, BILIARY TRACT AND PANCREAS;** Category 1 Credit; Contact: W. Dean Warren, M.D., Garland D. Perdue, M.D., Emory University School of Medicine, Atlanta 30322.

30-31—*Atlanta;* **THE TREATMENT OF ARTHRITIS—UPDATE;** Category 1 Credit; Contact: Colon H. Wilson, M.D., Emory University School of Medicine, Atlanta 30322.

30-31—*Chapel Hill, NC;* **SECOND ANNUAL CANCER RESEARCH MINI-SYMPOSIUM;** Category 1 Credit; Contact: University of North Carolina School of Medicine, Chapel Hill, NC 27514.

30-April 1—*Atlanta;* **PHARMACOLOGY FOR ANESTHESIOLOGISTS;** Category 1 Credit; Contact: John E. Steinhaus, M.D., Emory University School of Medicine, Atlanta 30322.

30-April 1—*Atlanta;* **GASTROENTEROLOGY—THE HOLLOW ORGANS;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Division of Continuing Education, Medical College of Georgia, Augusta 30901.

30-April 1—*Lake Guntersville State Park, AL;* **PRACTICAL OBSTETRICS AND GYNECOLOGY FOR THE PRIMARY CARE PHYSICIAN;** Contact: Mrs. Carol C. Malone, The University of Alabama in Huntsville, School of Primary Medical Care, Continuing Medical Education Office, The Ambulatory Care Center, 201 Governors Dr., S.W., Huntsville, AL 35801.

31-April 2—*Atlanta;* **BASIC CLINICAL ELECTROCARDIOGRAPHY AND ARRHYTHMIA MANAGEMENT;** Contact: William E. James, Ph.D., One Inverness Dr., Englewood, CO 80110.

31-April 4—*New Orleans;* **NEW ORLEANS GRADUATE MEDICAL ASSEMBLY: THE HIGH RISK PATIENT;** Category 1 Credit; Contact: New Orleans Graduate Medical Assembly, Room 1538, Tulane Medical Center, 1430 Tulane Ave., New Orelans, LA 70112, PH: 504/525-9930.

APRIL

3-5—*Atlanta;* **CLINICAL GENETICS FOR THE PEDIATRICIAN;** Category 1 Credit; Contact: Richard W. Blumberg, M.D. or Louis J. Elsas II, M.D., Emory University School of Medicine, Atlanta 30322.

5-7—*Atlanta;* **TECHNIQUES IN ORTHOPAEDIC SURGERY;** Category 1 Credit; Contact: Georgia E. Dreger, Ed.D., 107 Medical Administration Bldg., Emory University, Atlanta 30322, PH: 404/329-5535.

6-7—*Marietta;* **THE HUMAN RESPONSE TO CHANGE: COBB COUNTY MEDICAL SOCIETY ANNUAL SYMPOSIUM;** Contact: Kennesaw College, Marietta 30061, PH: 404/422-8770.

6-7—*Pine Mountain;* **6TH ANNUAL CONFERENCE ON PERINATAL MEDICINE;** Contact: Micki L. Souma, M.D. or Louis I. Levy, M.D., Perinatology, The Medical Center, P.O. Box 951, Columbus 31902.

6-9—*Atlanta;* **1978 SPRING INSTITUTE AHME (Association for Hospital Medical Education);** Contact: Ms. G. M. Coleman, 1911 Jefferson Davis Highway, Suite 905, Arlington, VA 22202.

14-15—*Atlanta;* **CORONARY ARTERY DISEASE: CURRENT TRENDS AND CONCEPTS;** Contact: Dr. Arnoldo Fiedotin, St. Joseph's Hospital, 5665 Peachtree-Dunwoody Rd., Atlanta 30340.

24-25—*Atlanta;* **CLINICAL ASPECTS OF FAMILY PLANNING FOR PHYSICIANS;** Contact: Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303.

25-28—*Atlanta;* **CLINICAL BIOFEEDBACK TRAINING, IV;** Category 1 Credit; Contact: Department of Rehabilitation Medicine, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

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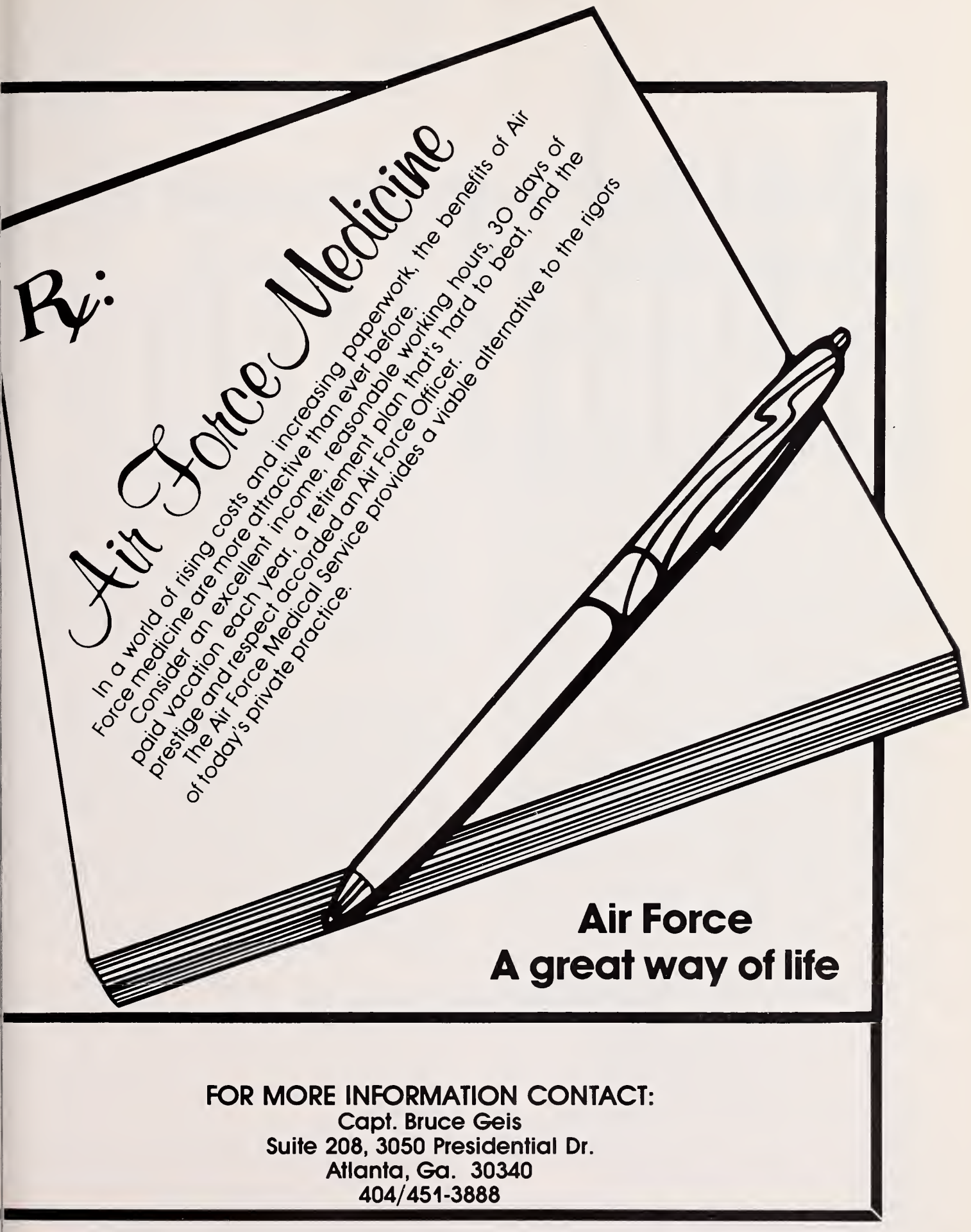
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Carbon monoxide (CO) is one of the most widely encountered toxic gases that is likely to have a deleterious effect on man and animals.

Mortality from Carbon Monoxide in Georgia 1961-1973

FRANK S. LISELLA, Ph.D., WILMA JOHNSON, M.S.P.H., *and* KENNETH HOLT, M.S.E.H., *Atlanta**

CARBON MONOXIDE (CO) IS COLORLESS, odorless, tasteless, non-irritating, and results from the incomplete combustion of organic matter. The gas may develop whenever a flame touches a surface that is cooler than the ignition temperature of the gaseous part of the flame.[1] Fuel-fired clothes dryers, water heaters, and gas and coal space heaters can be significant sources of carbon monoxide in the home setting if they are not effectively vented or maintained.

Carbon monoxide is absorbed only through the lungs and its toxicity is due to the fact that it combines with hemoglobin to form carboxyhemoglobin (COHb). Hemoglobin in this form is unavailable for the transport of oxygen. Hemoglobin combines with the same amount of CO as it does with oxygen, and both gases react with the same group in the hemoglobin molecule.[2] Up to the point where CO enters the erythrocytes, its behavior is much like that of oxygen. When CO contacts the erythrocytes, however, its behavior differs sharply because its affinity for hemoglobin is approximately 210 times as great as that of oxygen. Thus, in the presence of CO, the blood takes up 210 times as much CO per unit of partial pressure.[3] Death is likely to occur when the blood is saturated with 60-80% carboxyhemoglobin.

Each year in the United States, an estimated 10,000 persons seek medical attention or lose one or more days of normal activity because of carbon monoxide intoxication.[4] Annually, at least 1,400 persons die from accidental exposure to high concentrations of carbon monoxide and approximately 2,300 persons die as the result of suicidal involvement with lethal levels of this chemical.

* Environmental Health Services Division, Bureau of State Services, Center for Disease Control, Department of Health, Education and Welfare, Atlanta, Ga. 30333.

Situations in Georgia

Other than frequency data, however, specific epidemiologic information relating to the impact of carbon monoxide intoxications on mortality in Georgia is lacking. The authors sought to resolve this disparity by conducting a review of all death certificates which listed CO poisoning as the primary or contributing cause of death. This paper is a report of that investigation.

Procedure

Arrangements were made with the Georgia Department of Human Resources to provide copies of the death certificates which were filed in the 13-year period 1961-1973 (1973 being the latest year for which information was available). The name and address of the decedent was obliterated so that confidentiality could be maintained. Each of the 802 certificates was reviewed and the pertinent information was placed on a computer-compatible form. The data was subsequently key-taped and entered into an IBM 370 computer.

Results

Manner of Death—Of the 802 events in which carbon monoxide was involved, 464 (57.9%) were classified as accidental, 335 (41.8%) suicidal, one was homicidal, and two occurred under unknown circumstances.

Month and Year of Occurrence—The greatest frequency of deaths was recorded during the winter months—115 in January and 103 in December. Accordingly, the lowest frequencies were observed in the summer months—29 in June and 30 in July.

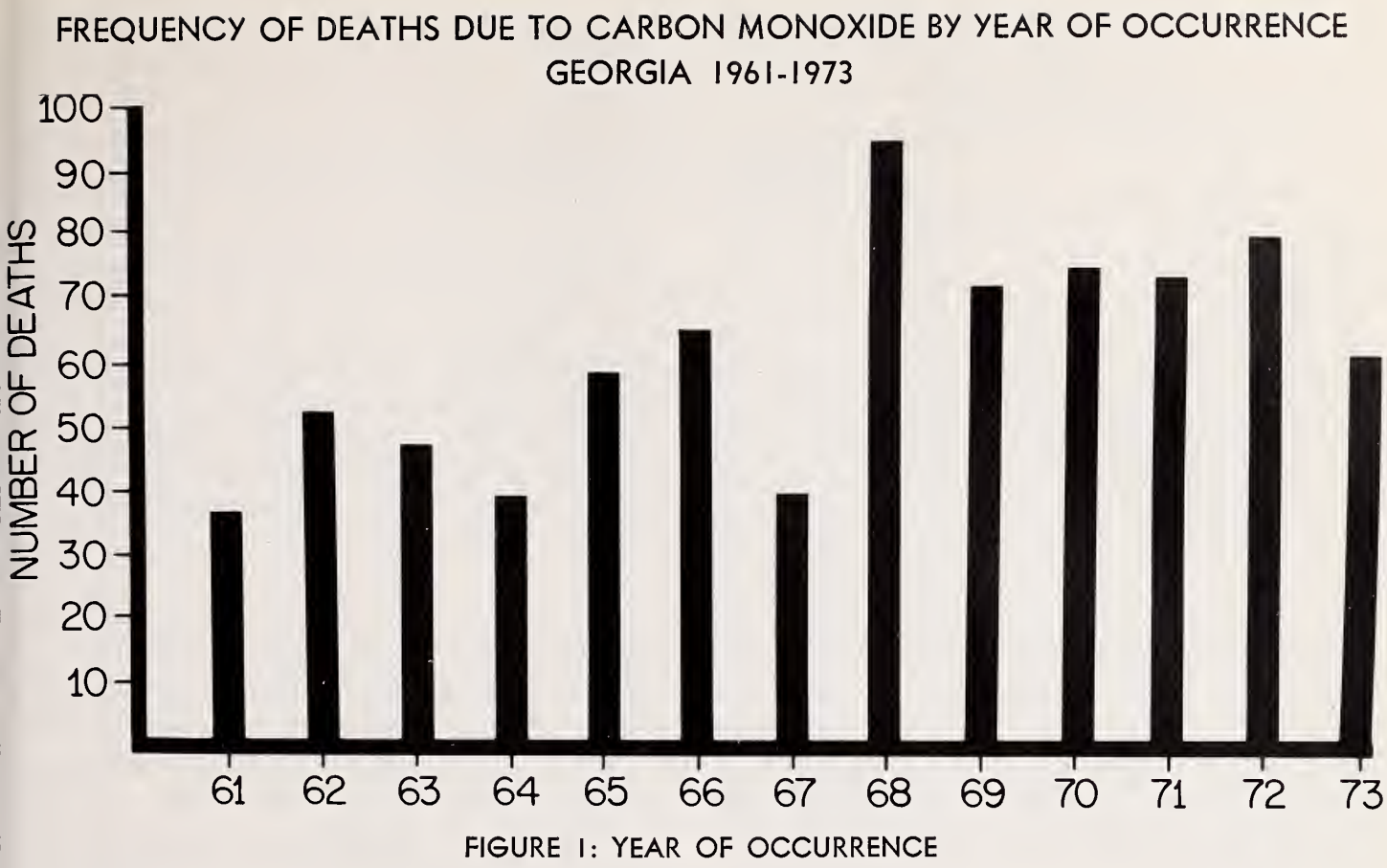


FIGURE 1: YEAR OF OCCURRENCE

The fewest number of deaths noted was 38 in 1961, the highest number 98 in 1968. (Figure 1.)

Age, Race, Sex—The deaths reported as being accidental and suicidal were compared according to the age, race, and sex of the victim. Of those categorized as being accidental, 279 (60.1%) occurred among whites whereas 183 (39.4%) involved blacks. By using information from the 1970 census, the crude death rate for blacks was 1.5 per 10,000, almost twice that for whites at 0.8 per 10,000. Within the races, the rates were higher for males—white males (183) 1.1 per 10,000, black males (123) 2.2 per 10,000, and white females (96) 0.6 per 10,000, black females (60) 1.0 per 10,000.

By five-year age groups (including all races), age-specific death rates ranged from 0.2 per 10,000 for ages 11-15 to 1.8 per 10,000 for persons 41-45 years old.

The data on suicidal involvement reflected a different pattern. Of the total number of suicides 329 (98.2%) involved whites whereas only 6 (1.8%) involved black individuals. The resulting race specific rates were 1.0 per 10,000 for whites and 0.1 per 10,000 for blacks.

Marital Status—The marital status of each individual as recorded on the death certificate was noted. Of the total deaths, 423 or 52.7% of the individuals were married. When the suicidal cases were com-

TABLE 1

NUMBER AND PERCENT OF DEATHS DUE TO CARBON MONOXIDE POISONING BY MANNER OF DEATH AND MARITAL STATUS—GEORGIA 1961-1973

Marital Status	Manner of Death: Accident	%	Suicide	%	Homicide	N/A	Total	%
Married	186	40.1	235	70.1	1	1	423	52.7
Never married	155	33.4	44	13.1		1	199	24.8
Widowed	42	9.1	11	3.3			54	6.7
Divorced	54	11.6	37	11.1			91	11.4
Separated	19	4.1	7	2.1			26	3.3
Not stated	8	1.7	1	0.3			9	1.1
Total	464	100	335	100	1	2	802	100

TABLE 2

GEORGIA COUNTIES RECORDING TEN OR MORE CO DEATHS—1961-1973

County (County Seat)	No. Deaths	Per Cent of Total*
Bibb (Macon)	16	3.4
Chatham (Savannah)	24	5.1
Cherokee (Canton)	10	2.1
Clarke (Athens)	17	3.6
Cobb (Marietta)	30	6.4
DeKalb (Decatur)	85	18.0
Dougherty (Albany)	13	2.8
Fulton (Atlanta)	186	39.5
Gwinnett (Lawrenceville)	13	2.8
Muscogee (Columbus)	17	3.6
Richmond (Augusta)	26	5.5
Troup (LaGrange)	21	4.4
Whitfield (Dalton)	13	2.8
Total	471	100.0

* Percent of sum of those counties reporting 10 or more deaths.

pared to those of accidental origin, 70.1% of the suicide victims were married whereas only 40.1% of the victims involved in an accidental exposure were married. (Table 1)

Place of Incident—The preponderance of the deaths noted took place in the home environment or in association with a vehicle. Of those occurring in the home (277), 133 (48%) were attributable to poorly ventilated heaters and 143 (51.6%) were the outcome of a fire in the dwelling.

Of the 463 occurring in association with a vehicle, 452 (97.6%) were linked with poor ventilation and only 8 (1.7%) were ascribed to a fire.

County of Occurrence—Table 2 is a listing of those counties within which ten or more deaths were noted during the study period. Of these 13 counties, the highest death rate was noted in Troup (county seat of LaGrange) at 4.7 per 10,000 residents.

Discussion

This review illustrates that fatal intoxication by carbon monoxide represents a subtle, but preventable, aspect of mortality in Georgia. The high number of accidental events associated with either the home setting or vehicles reinforces this premise. Although it was not possible to incriminate specific types of appliances (gas furnaces, hot water heaters, etc.) because of the limited information on the death certificate, postulations can be made about the probable cause of many of the events. Noteworthy among these is the tendency for males to repair vehicles in confined spaces with inadequate ventilation while the engines are operating. Persons who have an inadequate knowledge or disregard for the potential effects of CO in situations where it is being produced in abundance could hardly be expected to be aware of the more pernicious sources of the agent in the home environment—fuel-fired appliances.

The review further illustrates the sustained role of CO as a suicidal agent. Difficulties are often encountered in attempting to segregate the accidental vs. suicial intent of some of the cases, particularly those which occur in garage settings. Even allowing for this factor, the data reflected a disproportionate number of suicides among white males.

The study points out the need for health authorities to implement programs to advise the public on the hazards associated with prolonged exposure to carbon monoxide.

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Frequency of Fire Ant Stinging in Lowndes County, Georgia

WAYNE YEAGER, M.D., *Valdosta**

SINCE IMPORTATION IN THE LATE 1930's or early 1940's, the red imported fire ant, *Solenopsis invicta,* has efficiently adapted to the environment of the southeastern states. They fiercely defend their nests by stinging intruders and have become a public health hazard and an economic problem on agricultural land.

Fire ant stings are painful and a few persons are injured seriously enough to require medical care. In some instances, stinging damage progresses to invasive inflammatory lesions and necrosis of the skin and subcutaneous tissues. Death due to stinging rarely occurs and is usually due to shock and hyperallergic reaction to the ant venom.

The typical fire ant mound is about 25 to 30 cm in height, but may be as high as 100 cm in heavy clay soils. When the mound is disturbed, thousands of reddish-brown worker ants scurry over the breached nest. The workers show a continuum of sizes, ranging from 2.6 to 6.0 mm in length. *S. invicta* minor workers carry enough venom for multiple stinging and the major worker carries twice the venom of the small ant. White larval "brood" will be seen constantly moved by worker ants since they are legless and completely dependent upon the workers for food and care.

Imported fire ants sting by locking their specialized mandibles to the skin and injecting venom through an intricate sting apparatus located in the posterior of the gastor (abdomen). The unique nonprotein venom is highly destructive by cellular lysis and hemolysis. The lesion is located in and below the epidermis in the corium and is a hard and tough pustule with a center of necrotic debris, plasma, white cells and hemolized red cells. The initial stings may be succeeded by ulceration and tissue necrosis. The most critical clinical problem in *S. invicta* stinging happens when severe hyperallergenic reaction and shock occur. Hypersensitivity may be suspected when the sting sites are surrounded by large erythematous whelps.

The potential of serious fire ant accidents is very real and constitutes an important health hazard

Efforts to eradicate fire ants have not been successful for numerous reasons and control programs have had limited success. EPA is withdrawing its registration for mirex, the only practically effective pesticide, in 1978 because of the finding of residues in wildlife and humans and because it is suspected of being a carcinogen. Consequently, no good control methods are available for large scale use and human beings are frequently exposed and stung by fire ants in Georgia.

The Study

The purpose of this study was to measure the frequency of stinging to determine the magnitude of the problem in an average community of people. The study was done in Lowndes County which sustains infestation ranging from a few to over a hundred mounds per acre. A sample of 156 families, 72 in rural areas and 84 in the city of Valdosta, was selected and deliberately biased to achieve even coverage of the whole county regardless of infestation concentration.

Initially the families were composed of 508 persons, but because of dropouts during the year, the average number of persons observed was 438 persons. Each family was visited to establish basic family data and regular telephone communication was maintained for the year. Each family was interviewed monthly for stinging experience. Fire ant stings were counted as person-sting-units, defined as one person stung at least once per month. The extent of stinging was defined as mild if less than 10 stings, moderate if 10-20 stings, and severe if more than 20.

Less than 5% of the stinging reported was severe enough to require professional medical care. The frequency of stinging events was expressed in attack rates per 100,000 persons. Fire ant attack rates per 100,000 by quarterly intervals were adjusted for

* District Director of Health of the South Georgia Health District, 316 Cowart Ave., Valdosta, Ga. 31601. This paper was the result of a joint project with the U.S. Department of Agriculture, Agricultural Research Service, Southern Region, Gainesville, Fla., supported by contract #105-835-ARS-76.

TABLE 1

FIRE ANT ATTACK RATES PER 100,000 PERSONS IN LOWNDES COUNTY, 1976

Annual Quarter, 1976	January-March	April-June	July-September	October-December
City	4,700	9,040	19,880	560
County	13,940	27,190	27,050	2,730
Combined or central tendency	9,050	17,590	23,920	1,390

number of persons exposed during each quarter in Lowndes County, 1976.

Comments

The data indicated that, through the year, a significant attack rate occurred. This statement was tested by computing the probability of stinging events among the average 438 persons exposed with stinging rate of 13.83 percent. Out of a random sample of five people, the odds are better than even (0.52672) that one person will be stung per month.

Attack rates were higher in summer months and sting rates were higher in the rural areas where exposure is greater. The potentiality of serious fire ant accidents is constantly present in the state and constitutes an important health hazard. It is probable that severe stinging will happen and the possibility of severe, life-threatening hyperallergic reactions increases as stinging events continue.

Finally, fire ant stinging should be medically respected and physicians should be advocates for thoughtful control programs which will reduce infestation to a minimum and, at the same time, conserve the Georgia environment.

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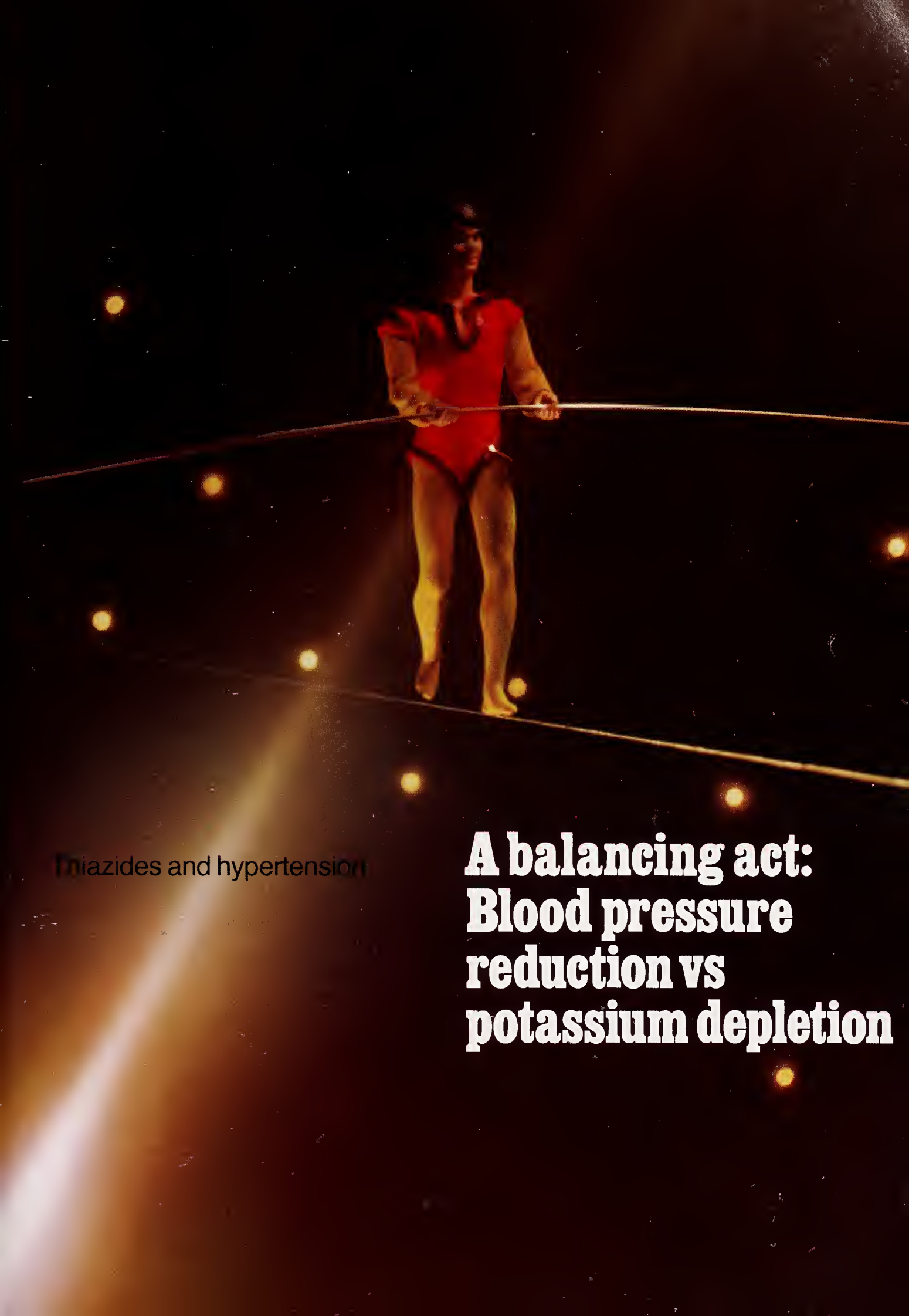
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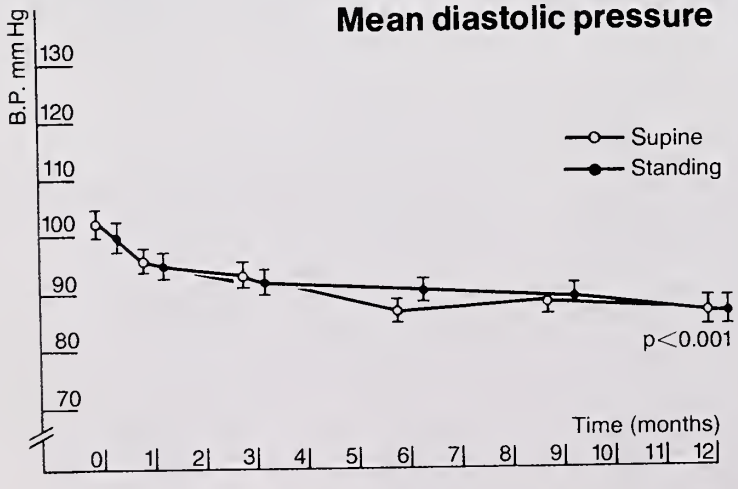
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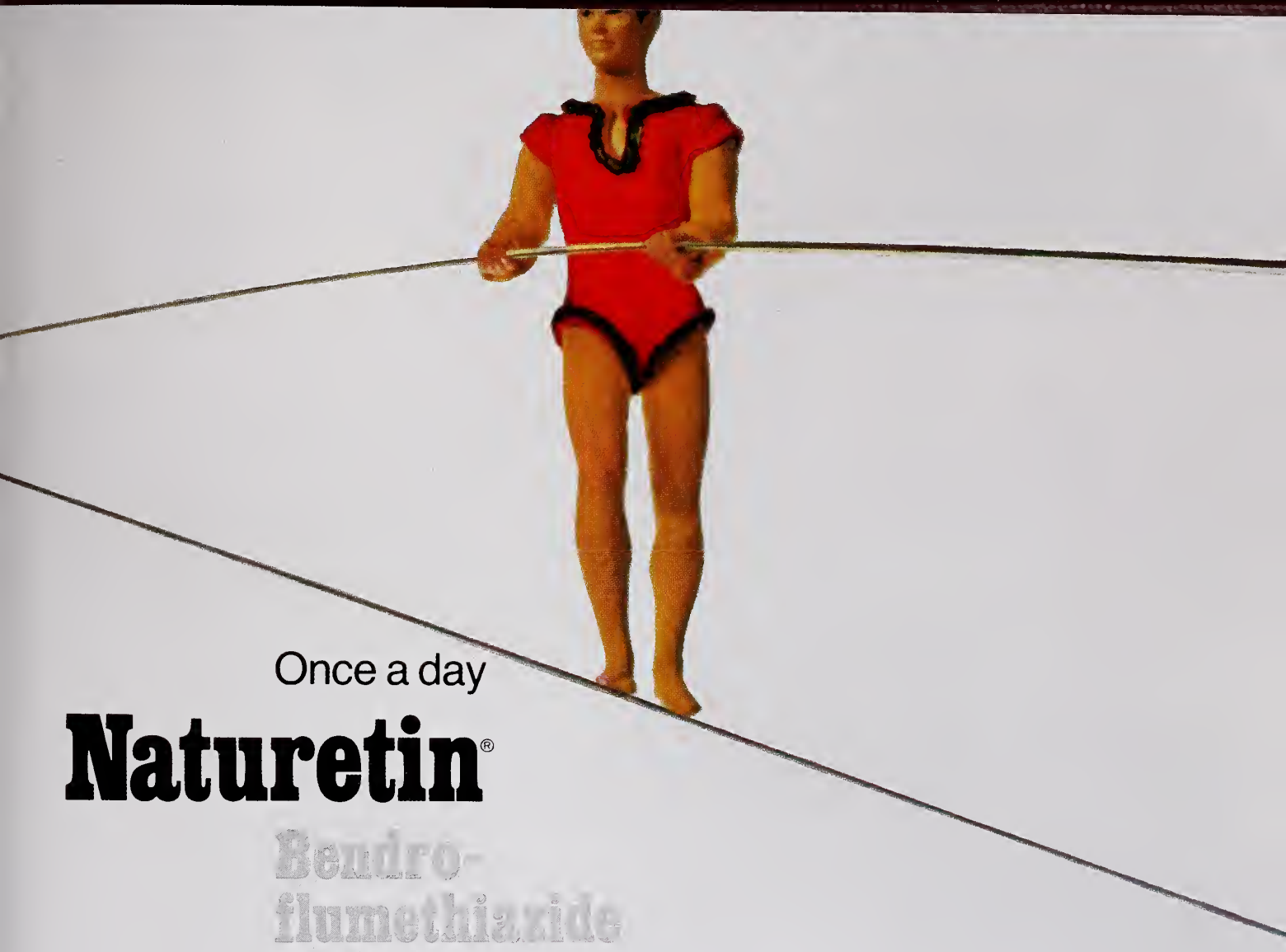
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*Wilkinson PR et al: The Lancet 1:759-762, 1975.



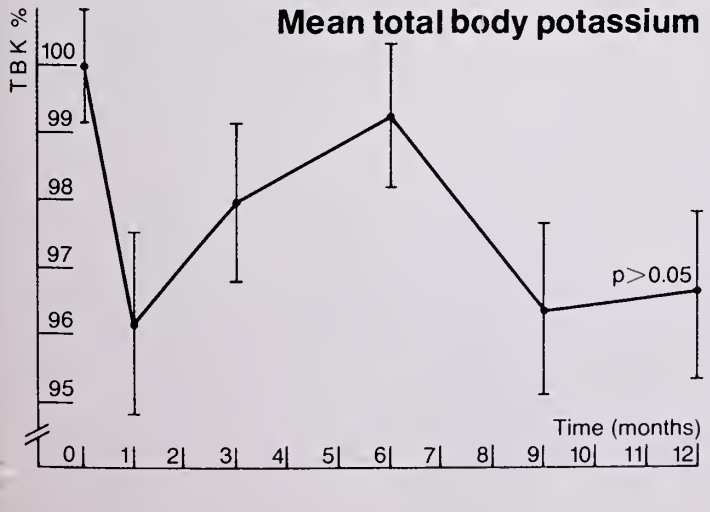
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ACTIONS
The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS
Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS
Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS
Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS
Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS
Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION
Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE
Store at room temperature; avoid excessive heat.

HOW SUPPLIED
2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

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Atypical Measles as a Cause of Measles Outbreak

E. NOEL PRESTON, M.D., *Atlanta**

FOLLOWING EXPOSURE IN THEIR physician's office to a 14-year-old male, four children aged 11 months, 13 months, 14 months and 4 years developed serologically proven measles. None of the children had been immunized previously against measles.

The adolescent (J.B.) had received an unknown type of measles vaccine in 1965 at age 2½. He was the last patient of the morning seen in his doctor's office on 2/23/77, and presented with wheezing, headache, and cough of two days duration, marked pharyngitis, tender enlarged cervical lymph nodes, a dry hacky cough, a flat red rash of the face and torso, and fever of 101°. His white blood cell count was 5,000 and he was sent home on symptomatic treatment after a throat culture was obtained. His throat culture was negative for streptococcal infection, but he returned the next day with fever of 104°, and a brawny red urticarial confluent rash of the face, that extended to macular, nonpapular lesions of the trunk and extremities. His gums were swollen and pustular, and he had a petechial palate. A CBC showed 3,200 wbc's, 45% hematocrit, 46 polys, 14 bands, 26 lymphocytes, 12 monocytes, and 2 eosinophils. He was started on erythromycin 400 mg Q.I.D. and was seen the next day, when his fever had declined and the rash had faded. He still had pustular swollen gums, but his pharyngitis was diminished and his cervical adenopathy was less. A repeat CBC showed 4,500 wbc's, 45% hematocrit, 24 polys, 2 bands, 66 lymphocytes, 6 monocytes and 2 eosinophils.

Twelve days later, a 13-month-old girl (A.M.) who had been the first afternoon patient seen on 2/23, presented with fever of 102.5R, cough, and mild pharyngitis. She was treated symptomatically, but returned in two days with anorexia, puffy eyelids, conjunctivitis, shoddy cervical nodes, and a faint macular red rash of the face.

Children with measles may present with a variety of symptoms other than a rash

The author's 11-month-old daughter (E.P.) and the adolescent had met in the waiting room on 2/23. Thirteen days later, she developed serous rhinorrhea, conjunctivitis, pharyngitis, pulmonary rales, a flat, red, blanching rash of the face and torso, and rectal temperature of 103°. Chest X-rays showed perihilar infiltrates, and she was started on ampicillin 125 mg Q.I.D. after receiving benzethine penicillin 1.2 million units. Acute serum for rubeola-titers was drawn, and the adolescent was recalled for a convalescent titer only.

A 4-year-old girl (B.C.) had been to the office 2/23 and had played in the waiting room with A.M. and the next patient, A.W. Fourteen days later, she presented with headache, pharyngitis, cervical lymph node enlargement, vomiting, and oral temperature of 102.4°. Her throat culture was negative for streptococcal infection and her wbc count was 8,100. Three days later, she developed a red facial rash.

Fifteen days after visiting the office, a 14-month-old girl (A.W.) presented with cough, conjunctivitis and rectal temperature of 104.6°. She had a macular, erythematous blanching rash of the face and torso. She had a large, swollen tongue and, although thirsty, could not drink. Hospitalization appeared necessary, but because of the contagiousness of her illness, a naso-gastric tube was inserted and taped in place.

Her mother, who was an attendant at a hospital

* Dr. Preston's address is 3644-E Chamblee-Tucker Road, Atlanta, Ga. 30341.

intensive care unit, was given a syringe and a supply of oral electrolyte solution. She was instructed to administer 450 ml of fluid overnight and to return the next day. The infant received benzethine penicillin 1.2 million units, and was started on ampicillin 125 mg Q.I.D. The next morning the temperature had diminished to 101°, the tongue was normal size, and the baby was drinking easily and urinating frequently.

Serologic titers were obtained from the children at the onset of their rashes, and convalescent specimens were obtained two weeks later. The data are as follows:

Patient	*Acute Titer*	*Convalescent Titer*
J.B.	Not obtained	1:256
A.M.	1:8	1:128
E.P.	1:8	1:256
B.C.	1:8	1:256
A.W.	1:8	1:256

Comment

Children immunized in the early days of measles prevention programs are now adolescents who not only can contract clinical measles disease, but may also transmit it to susceptible, non-immunized children. Many pediatricians who have never seen measles may not suspect it as a cause of fever, sore throat, and cough in their adolescent patients, especially if those patients give a history of previous measles immunization.

Children with measles may present with a variety of symptoms other than a rash. Some may present with vomiting, probably secondary to the dry barking cough associated with measles. Common symptoms associated with measles include conjunctivitis, rhinorrhea, coughing, cervical adenopathy, sore throat, and fever, which usually precede the rash by several days.

Measles is not a benign childhood disease; complications include otitis, pneumonia, obstructive laryngotracheitis, encephalitis, and dehydration. Antibiotic therapy is justified for otitis and pneumonia, but is not routinely given to all children with measles. Children with measles will require hospitalization if they develop obstructive laryngeotracheitis or encephalitis.



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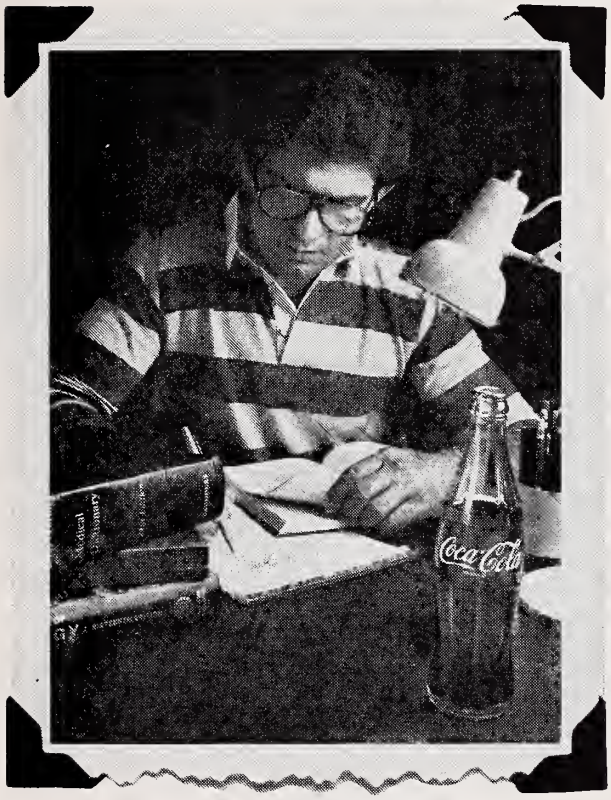
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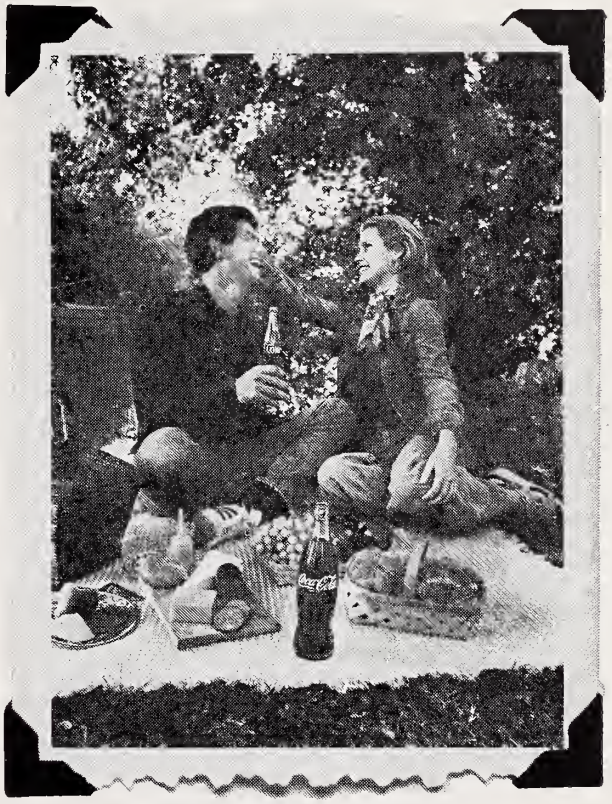
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Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

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Intramural Mass of the Duodenum

GEORGE W. VEALE, M.D., CECILIO R. POYATOS, M.D., *and*
ZEYNEL A. KARCIOGLU, M.D., *Atlanta**

Dr. George W. Veale: This 62-year-old male entered the hospital with the chief complaint of coffee-ground vomitus and a melanotic stool which occurred intermittently for three to four months prior to admission. The patient had a hematocrit of 37.5 and blood pressure of 160/100. Dr. Poyatos, will you please comment on the X-ray findings?

Dr. Cecilio R. Poyatos: Several views of the upper G.I. series show a well-defined, rounded, smooth filling defect in the upper portion of the duodenal bulb which measures about one cm. in diameter and seems to be covered by an intact mucosa (Fig. 1). No intrinsic mass is appreciated and the remainder of the study is unremarkable.

Dr. Veale: Before you give your differential diagnosis, this identical defect is seen on a previous upper G.I. series of 1974, two years ago.

Dr. Poyatos: A differential diagnosis of an intramural lesion which appears benign and shows no change in two years should include an adenoma, lipoma, Brunner's gland adenoma, leiomyoma or hemartoma. In this particular region, an ectopic pancreas should also be considered.

Less likely possibilities due to the long-standing presence and appearance are edematous changes associated with peptic ulcer disease or inflammatory processes, impacted gallstones, blood clots attached to the mucosa or foreign bodies.

Other uncommon lesions to be considered include papillomas, carcinoids, angiomas, myxomas, spindle cell tumors, intraluminal diverticula and intramural varices.

From the list of possibilities, the most likely lesions to bleed are leiomyomas; however, no signs of ulcerations of the mucosa are identified.

Dr. Veale: Additional clinical information obtained are a negative liver scan and negative 24-hour HIAA. A wedge excision was done and Dr. Karcioglu will comment on the pathological findings.

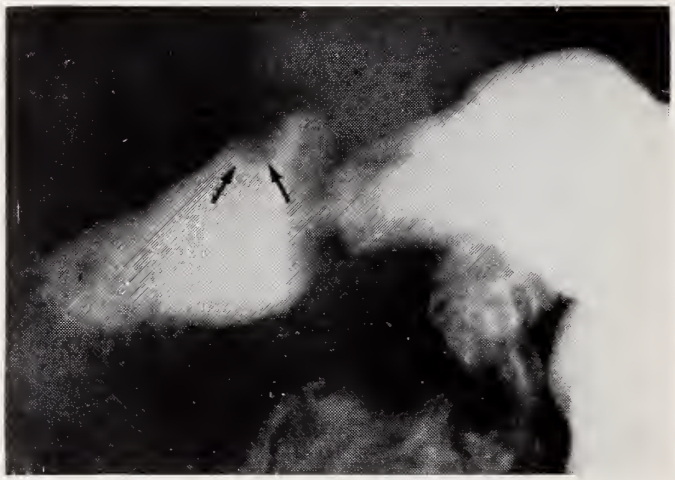


Figure 1—Upper G.I. series demonstrating a small, intramural, submucosal lesion in the superior portion of the duodenal bulb.

Dr. Zeynel A. Karcioglu: This lesion was first diagnosed by morphological appearance as a carcinoid tumor with a duodenal biopsy. The nodule from the wedge resection of duodenum measures approximately 1 cm. in diameter, is located in the mucosa and submucosa of the bowel and does not extend into the muscle layer or serosa. Microscopically, it is composed of small, uniform cells which are columnar and polygonal in shape. The biopsy material and the duodenal tumor revealed negative argyrophil and argentaffin reactions. Primary tumors of the duodenum are uncommon and carcinoids of this region are among the least common tumors. In a large series, Zakariai, et al. reported one case of duodenal carcinoid out of 12,239 G.I. malignancies (36 duodenal tumors). In another series of 62 carcinoids from Japan, Soga and Tazawa reported five duodenal lesions. On the other hand, the incidence of carcinoid of the entire ileum, relative to the malignant tumors of this organ, is quite striking; about 25% of all small bowel malignancies are carcinoids. Most of the duodenal carcinoids which arise from the primitive foregut are small, intramural lesions

* Emory University School of Medicine, Departments of Radiology and Pathology, Atlanta, Ga. 30303.

and do not produce the syndrome.

Prognosis of this patient will probably be good due to the small size of the lesion with no invasion of serosa and no liver metastases. Histologically, there is no difference between benign and malignant carcinoids. Therefore, the diagnosis of malignancy must be based on the extent of invasion into and beyond the wall of the organ involved. For example, in Zakariai's series, carcinoids which were limited to the mucosa and submucosa were usually asymptomatic and had an 85% five-year survival after local excision. On the other hand, tumors which had invaded into serosa and beyond showed a 5% five-year survival after radical surgery and other modalities of treatment.

Discussion

This case of duodenal carcinoid is a relatively common tumor occurring in a less frequently involved site most likely diagnosed by serendipity. Studies show carcinoids comprise 1.5% of G.I. neoplasms, with the most frequent enteral sites being the appendix (90%), terminal ileum, and rectum.

It is generally felt that the carcinoid syndrome occurs only with liver metastases and the systemic manifestations may consist of (1) paroxysmal flushing and other vasomotor symptoms, (2) dyspnea and wheezing, (3) recurrent episodes of abdominal pain and diarrhea, and (4) symptoms and signs of right-sided valvular disease of the heart. It is currently held that the flush in any given patient with the carcinoid syndrome is caused by a variety of biologically active substances, among which are Kallikrein and bradykinins rather than serotonins, as earlier thought. The biochemical hallmark of the majority of metastatic carcinoids is the increased excretion of 5-hydroxy indoleacetic acid (5 HIAA).

Surgical removal of the primary tumor is the best treatment and microscopic evidence of invasion of the muscularis of the bowel wall determines the extent of resection.

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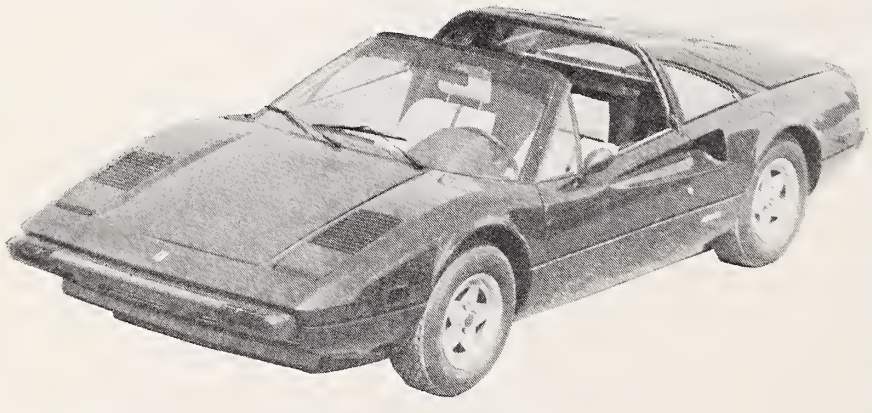
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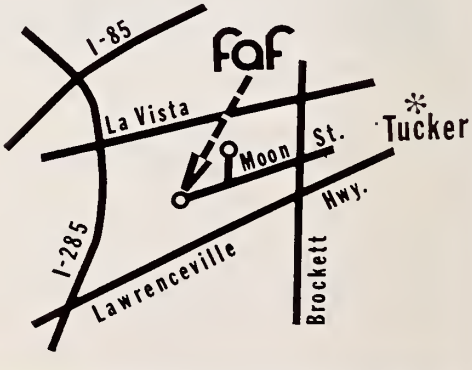
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Official Call

To the officers, delegates, and members of the Medical Association of Georgia to attend the 124th Annual Session of the House of Delegates

On Jekyll Island

April 14, 15 and 16, 1978

THE HOUSE OF DELEGATES will convene at 10:00 a.m. on Friday, April 14, in the Colony Hall of the Holiday Inn. The House of Delegates will be preceded by a General Session of Association Members at 9:00 a.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the Scientific portion of the meeting was separated from the business portion and is being held in November of each year.

Hotel Reservations

Officers, directors and delegates will have first priority for rooms at the Holiday Inn. Members of the Auxiliary to MAG will be headquartered at the Buccaneer Motor Hotel. MAG also has a room block at the Sheraton-by-the-Sea. Please use an official housing form on page 125 or write directly to the hotel of your choice.

Registration

Registration facilities will be maintained in the main lobby of the Holiday Inn just outside Colony Hall for delegates, alternate delegates, directors and all members. Registration hours will be as follows:

Thursday, April 13 . . . . . 4 p.m.-7 p.m.
Friday, April 14 . . . . . 7:30 a.m.-12:00 noon
Saturday, April 15 . . . . . 8:30 a.m.-5:00 p.m.
(After 12 noon, please come to MAG Headquarters office.)
Sunday, April 16 . . . . . 7:00 a.m.-12 Noon

Headquarters Office

The Association staff will maintain an office just off the lobby of the Holiday Inn.

Message Center

The Auxiliary to the MAG will maintain a message desk in the lobby of the Holiday Inn for the convenience of the membership. Names displayed on a projection screen in the House of Delegates will alert the members of an incoming message. The messages will be posted on a bulletin board at the message desk in the lobby.

General Sessions

The opening General Session will be called to order by the president, Milton I. Johnson, M.D., on Friday, April 14, at 9:00 a.m., in Colony Hall of the Holiday Inn. Featured during this opening ceremony will be the presentation of the report of the President of the Auxiliary to MAG and greeting of Mrs. Hoyt Gardner, first vice president of Auxiliary to AMA.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates on Sunday, April 16. At this time, the newly elected officers will be installed.

House of Delegates

The first session of the House of Delegates will convene on Friday, April 14, at 10:00 a.m. in Colony Hall of the Holiday Inn. At this time, nominations for MAG officers will be made. Reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference committees will be appointed and all resolutions and reports will be referred by the speaker to the appropriate reference committees.

The second session of the House of Delegates will convene at 12:30 p.m. on Saturday, April 15, in Colony Hall. Reference committees will report to the House at this time.

The third and final session of the House of Delegates will convene at 9:00 a.m. on Sunday, April 16, at which time the results of the election of officers will be announced and the remaining reference committee reports will be presented.

Reference Committees

According to the Bylaws of the Association, all resolutions and reports which contain recommendations must be referred to reference committees for

open hearings. All members are invited and encouraged to appear before the reference committees to express their views. The reference committees will open their hearings on Friday, April 14, two hours following the recess of the House of Delegates, or approximately 1:00 p.m., subject to announcement by the speaker.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Friday, April 14. The election will take place before the House of Delegates, Sunday, April 16. Delegates will be certified by members of the Credentials Committee and receive their ballots at the time. There will be appropriate voting booths and a secure ballot box. After the polls close at 9:00 a.m., the Tellers Committee will count the ballots and the results will be announced at the General Session following the adjournment of the House of Delegates. If it is necessary to have a run-off election, it will be held during the House meeting.

GaMPAC Breakfast

This annual highlight of the Annual Session will be held on Saturday, April 15, in the Colony Hall of the Holiday Inn. U.S. Senator Sam Nunn will be the featured speaker at this event. All MAG and Auxiliary members are invited to attend.

President's Reception and Banquet

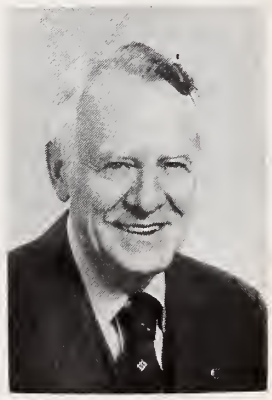
The Association will honor its president at a reception to be held at 6:30 p.m., Saturday, April 15, followed by the Awards Banquet. Also featured at this banquet will be addresses by John H. Budd, M.D., Cleveland, Ohio, president of the American Medical Association and Milton I. Johnson, M.D., MAG president. All members and their guests are invited to attend.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

To make your reservations, see pages 124-125.

AMA PRESIDENT JOHN H. BUDD, M.D.



John H. Budd, M.D., 1977-1978 President of the American Medical Association, will be the guest speaker at the president's reception and banquet on Saturday.

Dr. Budd has specialized in family practice and obstetrics and gynecology in Cleveland, where he has been a solo practitioner since 1937. Prior to his election at the 1976 Annual Convention in Dallas, he had been a member of the AMA's policy-making House of Delegates for ten years when he was elected to his first three-year term on the Board of Trustees in 1970. He was unopposed for re-election in 1973.

Long active in medical society activities, Dr. Budd is a past president of the Cleveland Academy of Medicine, a member of the Ohio State Medical Association, and a fellow of the American Academy of Family Physicians. During his decade of service as delegate to the AMA, he was chairman of the Ohio State Medical Association's nine-member delegation from 1962 to 1970. He was a member of the AMA's Study Committee on Planning and Development from 1967 to 1969, which was a forerunner of the present Council on Long Range Planning and Development. From 1974 to 1976, he served as vice president of the AMA Education and Research Foundation. He is a past chairman of the AMA Committee of Commissioners to the Joint Commission on Accreditation of Hospitals.

In 1967, Dr. Budd received the "Honors of the Academy" Award from the Cleveland Academy of Medicine. In 1973, the Academy bestowed its "Distinguished Membership Award" on him, an award which only 27 other members of the Academy have received. In 1974, the Academy commissioned the painting of his portrait which is now displayed in the foyer of the Academy offices, making him the first physician to be so honored during life. Also in 1974, the Ohio State Medical Association awarded him its Distinguished Service Citation.

Dr. Budd's speech promises to be an enlightening and inspirational beginning for this year's Annual Session.

Officers of the Association
1977-1978



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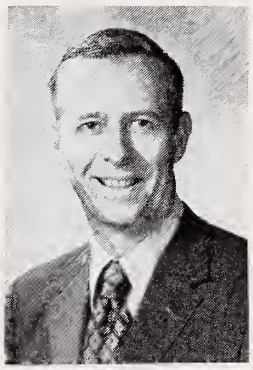
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OFFICERS

Position		*Term Ending*
PRESIDENT	Milton I. Johnson, Macon	1978
PRESIDENT-ELECT	Carson B. Burgstiner, Savannah	1978
IMMEDIATE PAST PRESIDENT	Fleming L. Jolley, Atlanta	1978
PAST PRESIDENT	David A. Wells, Dalton	1979
PAST PRESIDENT	J. Rhodes Haverty, Atlanta	1978
CHAIRMAN OF THE BOARD OF DIRECTORS	Joe C. Stubbs, Valdosta	1978
FIRST VICE PRESIDENT		
SECOND VICE PRESIDENT	L. Newton Turk III, Atlanta	1978
VICE CHAIRMAN, BOARD OF DIRECTORS	Jack A. Raines, Columbus	1978
SECRETARY	Earnest C. Atkins, Atlanta	1978
TREASURER	James H. Sullivan, Columbus	1978
SPEAKER OF THE HOUSE	L. C. Buchanan, Decatur	1980
VICE SPEAKER OF THE HOUSE	Jack Menendez, Macon	1980
EDITOR, *JMAG*	Edgar Woody Jr., Atlanta	1978

DIRECTORS AND ALTERNATE DIRECTORS

District	*Director*	*Alternate Director*	*Term Ending*
1	Leon E. Curry, Metter	Charles R. Richardson, Statesboro	1979
2	J. Dan Bateman, Albany	Sammie Dixon, Tifton	1979
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1979
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1980
7	Richard A. Griffin III, Cartersville	D. R. Mahan, Dalton	1980
8	Joe C. Stubbs, Valdosta	Michel A. Glucksman, Brunswick	1980
9	Harvey M. Newman, Gainesville	L. Austin Flint, Canton	1978
10	Edwin W. Allen Jr., Milledgeville	M. A. Hubert, Athens	1978
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Rodney M. Browne, Macon	† 1978
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1978
DeKalb Medical Society			
	Luther M. Vinton, Avondale Estates	Stanley P. Aldridge, Decatur	1978
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Lee H. Battle, Rome	1978
Medical Association of Atlanta			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1980
	T. J. Anderson Jr., Atlanta	William D. Logan, Atlanta	1978
	J. Harold Harrison, Atlanta	William C. Waters III, Atlanta	1979
Georgia Medical Society			
	Joseph A. Mulherin, Savannah	Joe L. Nettles, Savannah	1979
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1980
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Henry D. Scoggins, Augusta	1978

AMA DELEGATES AND ALTERNATE DELEGATES, JANUARY 1, 1978

Delegates	*Term Ending*	*Alternate Delegates*	*Term Ending*
C. Emory Bohler, Brooklet	12-31-79	F. G. Eldridge, Valdosta	12-31-79
F. W. Dowda, Atlanta	12-31-79	Charles D. Hollis, Albany	12-31-79
Harrison L. Rogers Jr., Atlanta	12-31-78	H. Hilt Hammett, La Grange	12-31-78
J. Dan Bateman, Albany	12-31-78	W. W. Moore, Atlanta	12-31-78

Component County Society Representation to the 1978 House of Delegates

(1977 CMS Member Count for 1978 Delegates to Annual Session—Tentative)

County Medical Society	*Number of Delegates*	*County Medical Society*	*Number of Delegates*
Altamaha	1	Elbert	1
Baldwin	3	Chattahoochee	2
Barrow	1	Cherokee-Pickens	1
Bartow	1	Crawford W. Long	4
Ben Hill-Irwin	1	Clayton-Fayette	3
Bibb	9	Cobb	11
Ogeechee River	2	Coffee	1
Burke	1	Colquitt	1
Carroll-Douglas-Haralson	2	Coweta	2
Georgia Medical Society	10	Decatur-Seminole	1

County Medical Society	Number of Delegates
DeKalb	12
Dougherty	4
Camden-Charlton	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin	1
Medical Association of Atlanta	49
Glynn	3
Gordon	1
Habersham	1
Hall	4
Peach Belt	2
Jackson-Banks	1
Jefferson	1
Laurens	2
McDuffie	1
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	8
Newton-Rockdale	1
Oconee Valley	1
Ocmulgee	1
Randolph-Stewart-Terrell	1
Richmond	15
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	2
Sumter	1
St. John's Parish	1
Telfair	1
Thomas Area	3
Tift	2
Troup	2
Upson	1
Walker-Catoosa-Dade	2
Walton	1
Ware	2
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than March 1, 1978. If no nominations and supporting data are received, no award will be made. No nominations for this award will be made from the floor. If given, this award will be presented on Saturday, April 15. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than March 1. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Saturday, April 15.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters office no later than March 1. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Saturday, April 15.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The name of the family physician, accompanied by supporting biographical data must be received at MAG Headquarters by March 1. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Saturday, April 15.

Official Program

(All functions of the House of Delegates will be held in the Holiday Inn)

THURSDAY, APRIL 13

4:00-7:00 p.m.	**General and Delegates Registration** *Lobby*

FRIDAY, APRIL 14

7:30 a.m.	**General and Delegates Registration** *Lobby*
9:00 a.m.	**General Session** *Colony Hall* Presiding: Milton I. Johnson, M.D., President Opening Ceremonies Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Russell E. Andrews Jr., Rome, Georgia Greetings: Mrs. Hoyt Gardner, Louisville, Ky., First Vice President, Auxiliary to the American Medical Association Announcements Recess
10:00 a.m.	**House of Delegates** *Colony Hall* Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker Presentation, Correction and Adoption of the Minutes of the 1977 House of Delegates Appointment of Convention Committees Nominations for Association Officers and AMA Delegates Reports of Officers and Committees Introduction of New Business Announcements Recess
1:00 p.m.	**Reference Committee Hearings** *Colony Hall*

SATURDAY, APRIL 15

8:30 a.m.	**General and Delegates Registration** *Colony Hall*
8:30 a.m.	**GaMPAC Breakfast** *Colony Hall* (All MAG members, Auxiliary members, and guests are invited to attend)

12:30 p.m.	**House of Delegates, Second Session** *Colony Hall*
6:30 p.m.	**President's Reception and Banquet** *Colony Hall* Presentation of Association Awards Family Physician of the Year Hardman Cup Civic Endeavor Award Distinguished Service Award Address: John H. Budd, M.D., President American Medical Association; Address by Milton I. Johnson, M.D. (All MAG members, Auxiliary members, and guests are cordially invited)

SUNDAY, APRIL 16

7:00 a.m.	**General and Delegates Registration** *Lobby*
7:00 a.m.-9:00 a.m.	**Polls Open for Election of Association Officers and AMA Delegates** *Lobby*
9:00 a.m.	**House of Delegates, Third and Final Session** *Colony Hall* Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker Invocation Reports of Reference Committees Announcements Announcements of Election Results Adjournment of House of Delegates
12:00 Noon	**General Session, Final** *Colony Hall* Presiding: Milton I. Johnson, M.D., President Installation of Officers Adjournment of 124th Annual Session

Welcome to Jekyll Island

To the Members of the Medical Association of Georgia:

On behalf of the Glynn County Medical Society, I would like to extend to you an invitation to attend the meeting of the House of Delegates April 14-16, 1978 at the Holiday Inn on Jekyll Island.

D. H. MANNING, M.D.
President, Glynn County Medical Society

Auxiliary 53rd Annual Convention

April 13-15, 1978 • Buccaneer Motor Lodge • Jekyll Island, Georgia

President's Greeting



SUNSHINE IS FOR sharing. The Auxiliary-MAG Convention is, too. The happy feeling that you get we hope will stay with you.

Please accept this as your invitation to participate in the culmination of the 1977-1978 Auxiliary activities. Each Auxiliary has stressed unity in various ways and now is the time to view what has been accomplished.

The Glynn County Auxiliary is hostess, along with Baldwin and Carroll-Douglas-Haralson County Auxiliaries serving as co-hostess. They are giving consideration to the meetings as well as time for pleasure.

There is an Auxiliary motto which says, "Join us. We can do more together." Please join us at the Buccaneer at Jekyll Island, Georgia, April 13-15, 1978. Mrs. Hoyt Gardner, First Vice-President of the Auxiliary to the American Medical Association, will be our special guest.

It is my sincere desire to have every physician's spouse join us for business and fun. Please help us strive for unity.

MRS. RUSSELL E. ANDREWS JR.
President
Auxiliary to the Medical
Association of Georgia

Welcome to Jekyll Island



I AM DELIGHTED to extend to everyone a cordial invitation to attend the annual convention of the Medical Association of Georgia. As President of the Auxiliary to the Glynn County Medical Society, I assure you we will be out en masse to help you enjoy your stay in the Golden Isles.

We all know that business sessions, which are the reason for the convention, will be held, but the weather should be nice and there will be time for that leisurely golf game, an invigorating tennis match, or a restful and relaxing stroll on the beach.

Please don't leave your wife behind, as there will be activities for her with the Auxiliary. We are looking forward to seeing you in the Golden Isles in April.

MRS. CARROLL TUTEN
President
Glynn County Medical Auxiliary

1978 Auxiliary Annual Convention Schedule

THURSDAY, APRIL 13	EVENT	LOCATION
2:00 p.m.-5:00 p.m.	Registration and Information	Lobby
2:00 p.m.-5:00 p.m.	Hospitality and Exhibits	Main Deck—A
3:00 p.m.-4:00 p.m.	Pre-Convention Executive Board Meeting	Main Deck—B
4:00 p.m.-5:00 p.m.	Orientation 1978-1979	Main Deck—C
6:30 p.m.-7:30 p.m.	Reception for 1977-1978 Executive Board	Buccaneer Room
FRIDAY, APRIL 14		
8:30 a.m.-5:00 p.m.	Registration and Information	Lobby

8:30 a.m.-5:00 p.m.	Hospitality and Exhibits	Main Deck—A
9:00 a.m.-10:00 a.m.	MAG General Session Auxiliary President's Address Introduction of Guests	Grand Ballroom Holiday Inn
10:30 a.m.-12:00 Noon	First General Session Guest Speaker Memorial Service	Main Deck—D, E, F
1:00 p.m.-2:00 p.m.	Luncheon	Buccaneer Room

SATURDAY, APRIL 15

8:30 a.m.-12:00 Noon	Registration and Information	Lobby
8:30 a.m.-12:00 Noon	Hospitality and Exhibits	Main Deck—A
8:00 a.m.-10:15 a.m.	Past Presidents' Breakfast	Lounge
9:00 a.m.-10:15 a.m.	Second General Session Awards Installation of Officers	Main Deck—D, E, F
10:15 a.m.-10:30 a.m.	Post-Convention Executive Board Meeting Awards	Main Deck—D, E, F
8:30 a.m.	Annual GaMPAC Breakfast	Colony Hall
6:30 p.m.-7:30 p.m.	MAG President's Reception and Banquet	Colony Hall

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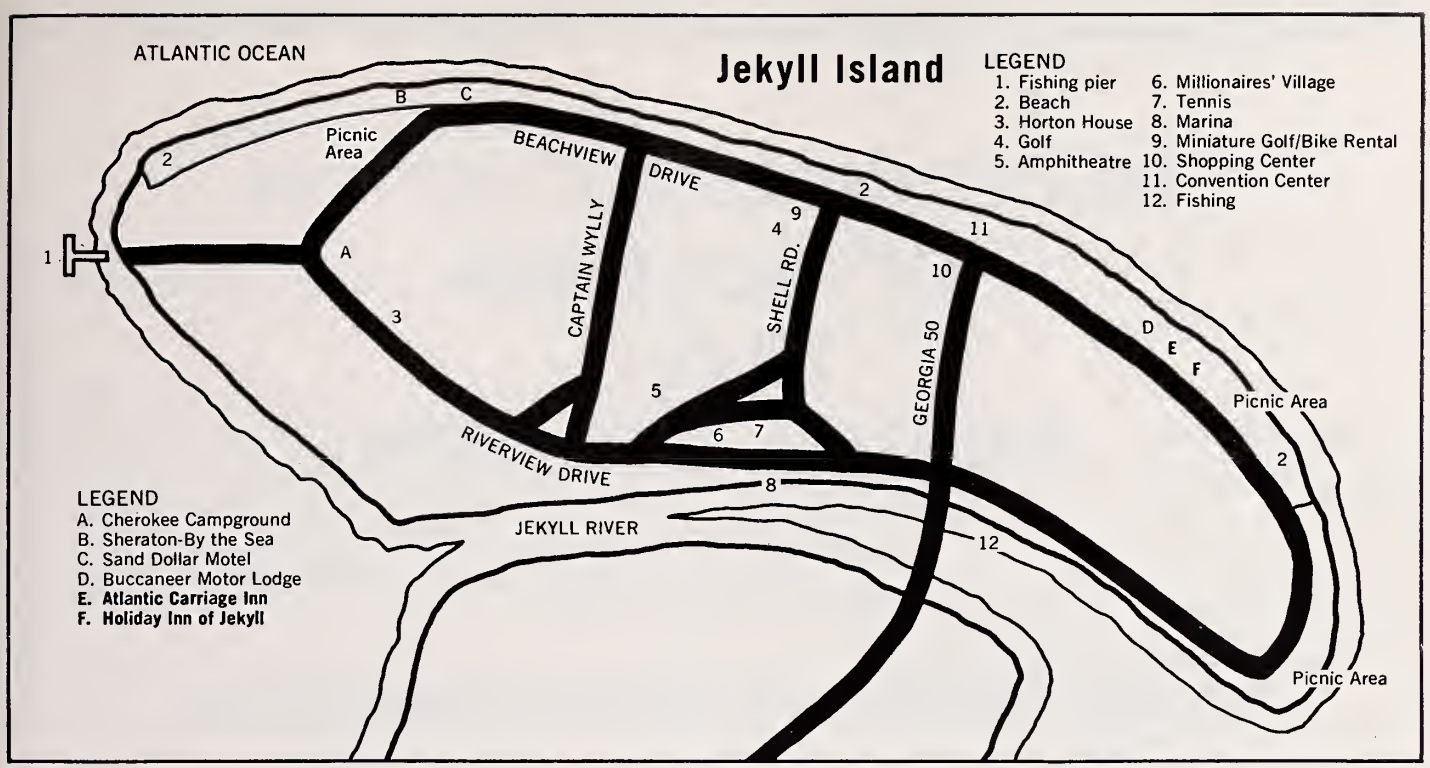
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1978 Annual Session

Jekyll Island
April 14-16

MEDICAL ASSOCIATION OF GEORGIA 124th ANNUAL SESSION

April 14, 15, 16, 1978
Jekyll Island, Georgia

HOTEL RESERVATION INFORMATION

1. The Holiday Inn has been designated as the Headquarters Hotel. Association officers, directors, and delegates will receive special housing forms for making their reservations at the Holiday Inn.
2. The Buccaneer Motor Lodge is the Headquarters for the Auxiliary to MAG.
3. Assignment of rooms will be made in the order of receipt by the hotel of choice. Please indicate a second choice so that the hotel of the first choice can forward the reservation, should they be completely booked.
4. Make your reservations early. Unreserved room blocks will be released on March 17.
5. DEPOSIT REQUIRED TO CONFIRM RESERVATIONS.

HOTEL DAILY ROOM RATES
(European Plan—Meals Not Included)

HOLIDAY INN:	200 South Beachview Drive, Jekyll Island, GA 31520 $25 Single; $29 Double
BUCCANEER MOTOR LODGE:	85 Beachview Drive, S., Jekyll Island, GA 31520 $27 Courtside Bedroom; $30 Oceanfront Bedroom; $33 Courtside Kitchenette; $36 Oceanfront Kitchenette. All rates for one or two persons. Extra persons $3 per day. Children under 16 free. Roll-aways and cribs $2 per day.
SHERATON-BY-THE-SEA	P.O. Box 3040, Jekyll Island, GA 31520 $33 One Bedroom Townhouse (two persons); $49 Two Bedroom Townhouse (four persons); $59 Three Bedroom Townhouse (six persons). Roll-away beds $3 per day; cribs $2 per day. Each townhouse consists of bedroom(s), living room, dining room and kitchen.

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April 14, 15, 16, 1978

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Type of accommodation ..... **for** ..... # **persons.**
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JOURNAL
of the medical association of
georgia
FEBRUARY / 1978







Jekyll Island
MAG ANNUAL SESSION
AMAG ANNUAL CONVENTION
APRIL 14-16, 1978







Enjoy Jekyll Island . . .

AS THE COVER DEPICTS, Jekyll Island has something for everyone, ranging from historical buffs to those who simply enjoy watching the golden sunset.

Jekyll Island, the site of early settlements by the French, Spanish, and British, was originally named "Ospo" by the native Indians and later was named "Ile de la Somme" by the French Huguenots who settled there in 1562. Its current name was given to it in 1736 by Georgia's founder, James Oglethorpe, in honor of one of his sponsors, Sir Joseph Jekyll.

During Jekyll's early turbulent history with the three nations vying for ownership of the island, pirates sailed freely along the Georgia coast, preying on coastal ships, and often burying their treasures on the shores of the island. During the nineteenth century, Jekyll was purchased by a wealthy Frenchman, Christopher Poulain du Bignon, in whose possession it remained until 1886, when it was sold to the Jekyll Club for $125,000.

The Jekyll Club, formed by a group of wealthy American families, bought the island for its members as an exclusive resort "secluded and warm enough to bask in the sun during the severe months of January, February and March." It was a common boast among the members at the time that "no unwanted foot ever touched the island." Visitors to the island were called "strangers" and their stay limited to two weeks. Ownership by the Jekyll Club continued until 1947, when the island was purchased by the state of Georgia for $650,000.

Once described by Cleveland Amory as "the greatest of the country's social islands," Jekyll Island is today a popular resort with three 18-hole golf courses and one 9-hole golf course, tennis, boating, fishing and sightseeing. For those who enjoy more casual relaxation, there are nine miles of uncrowded beach to stroll along or to lie upon and enjoy the panorama of white ships moving gracefully over the blue ocean against a backdrop of a fleece-lined sky or a rainbow-colored sunset.

Jekyll Island can be reached by car over a causeway from U.S. 17 or by air to Brunswick, St. Simons or Jacksonville.

About the Cover: The two buildings pictured are the Jekyll Clubhouse (top) and the Crane House (bottom). Photos courtesy of the Jekyll Island Convention and Visitors Bureau. Cover design by Bob Hamill.

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For Your Dining Pleasure

We asked everyone we knew who had been to Jekyll Island to tell us their favorite restaurant in the area. This grapevine approach just happened to yield a delectable dozen. Here are the 12 most often recommended . . .

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440 Kingsway, St. Simons
638-2844

2. BUCCANEER MOTOR LODGE
85 Beachview Dr., Jekyll Island
635-2261

3. CRAB TRAP
1209 Ocean Blvd., St. Simons
638-3552

4. EMMELINE & HESSIE SEAFOOD
St. Simons Causeway, St. Simons
638-9084

5. W. G. FOTTS
Mallory St., St. Simons
688-9694

6. HOLIDAY INN
200 S. Beachview Dr., Jekyll Island
635-3311

7. HOWARD JOHNSON'S MOTOR LODGE
3302 Glynn Ave., Brunswick
264-9111

8. KING & PRINCE BEACH HOTEL
King and Prince Road
638-3631

9. PIER 17
Ramada Inns-Glynn Ave.,
Brunswick, U.S. 341
265-1717 264-4444

10. RED BARN
Frederica Road, St. Simons
638-2844

11. SEA ISLAND YACHT CLUB
Kingsway, St. Simons
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12. SHERATON BY THE SEA
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The belief in the sanctity of life is the basis of the right-to-life philosophy

Right to Life, An Ethical Dilemma: A Physician's Viewpoint

PRESTON D. ELLINGTON, M.D., *Gracewood**

THERE HAS ALWAYS BEEN on-going discussion of the question of the termination (active or passive) of a socially unfit life and the dilemma of the severely defective infant. The physician in the intimacy of his conscience has often had to face this conflict.

If we ever regard an allocation-of-death policy for the developmentally disabled infant, then we must indeed anticipate its inevitable evolution to the excesses of the Hegelian rational utility philosophy that "whatever is rational is real and whatever is real is rational," and ktenology. It is one of the laws of psychology that destructive urges cannot remain limited or focused, but must inevitably spread and, ultimately, be directed against one's own self. This is an "all or none" law of fundamental psychological attitudes.

Infanticide which aims to improve the race or society by the elimination of children born with defects is not a new idea. In Sparta, the most pure of all the states of ancient Greece, the State decided whether a child at birth gave promise of maturing as a healthy citizen or whether he should be exposed on Mt. Tayetus. In order to prevent a competing line of royal descent, the offspring of sisters of central African kings were killed at birth. Religious motives mandated casting offspring to alligators in the Ganges River in India. Infants were sacrificed to the god, Moloch, in ancient Phoenicia and to the sun god by the Natchez Indians.

The eventually broadening evolution of this ideology could include, under the definition of a "useless and meaningless life," categories such as the senile, the unproductive, the chronically ill, the debilitated, or the brain damaged accident victim.

This ideology prompted the order issued by Adolph Hitler on September 1, 1939 when Dr. Karl Brandt was selected to supervise the medical section of all extermination programs. State institutions were required to complete reports containing certain vital information on all patients. All this appeared quite innocous enough, but the decisions regarding who was to die were based entirely on this information. Regardless of any other ideologies, the guiding philosophic principle was Hegelian in that moral, ethical, and religious values were replaced with that of "rational utility." This obviously could only result in a rapid decline in the standards of professional ethics of the medical profession.

Lay opinion was not to be ignored, but was propagandized by a most convincing trichotomy: (a) Infanticide of the obvious, suspected, or anticipated developmentally disabled, thus (b) obviates the need for society to provide services, to give support, and to assist handicapped persons and their families, thereby saving "useless" expenses, and, therefore, (c) would then preclude demands on the capacities of the family and community to deal with defective newborn infants.

Now, this trifurcation would be complete, except that: No man, even if he is unable to function in human ways, may be treated less than human without damage to our human-valuing sensitivities. Nuremberg should have taught us at least that. Auschwitz and Dachau began in those experimentations on institutionalized defectives.

Society must be careful not to succumb to the

* Director of Medical Services, Community Resource Unit, Gracewood State School and Hospital, Gracewood, Ga. 30812. This paper was presented at the annual meeting of the American Association on Mental Deficiency in New Orleans, La. on May 31, 1977.

nurture of the carefully spread notion of a new code of revolutionary ethics. It is the cunning of reason to have the passions work for its aims. Fortunately, in this democratic society today, there are elements that counteract these trends; the societies of parents whose offspring are afflicted are notable among them.

Birth imposes on mankind not only the assurance of death, but also the right to life. Interference with this right to life should be incompatible with man's consciousness. History through the centuries has shown it leads irrevocably to the mark of a deteriorating morality. In no society that has ever existed has any evolution of ideology survived that was not in a subtle way tempted with the Hegelian premise of "what is useful is right."

The bait of man as his brother's keeper attracts many noble spirits, but the poisonous hook lies hidden in man's power over his brother.

At a time such as the present, when there is so great a clamor that society must decide which infant shall die and which infant shall live, according to man-made guidelines, we might well seriously heed an admonition of Virgil in the *Aeneid: "Facilis descensus . . . hic labor est,"* which may be translated to mean that "it is easy to fall into a hole, but it may be very difficult to climb out of it."

We may be very sure that, if our society abandons our moral and ethical values of the sanctity of life to follow the swamp-lights of "rational utility" out into the bogs of this ideology, future generations must climb slowly and painfully back out of that foul morass to struggle again to regain these rights to life which this generation so thoughtlessly tossed away for a mere ideology.

Since much of mental retardation might be avoided by the knowledge of the methods of prevention, let us then apply ourselves instead to this task which is presented to us. With thousands of trained scientists carrying the battle against the enemy, mental retardation, at every point it should be evident to all of us that we are on the threshold of even greater developments. In this age of tremendous and unprecedented medical progress, there must be no inclinations to rest on the oars.

A life, a little gleam of time between two extremes, is a right . . . no second chance for evermore.

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MAG President Perry Dies

ON DECEMBER 30, 1977, Robert E. Perry Jr., M.D., president of the Medical Association of Georgia, died unexpectedly. Never before in its 128 years has MAG lost an incumbent president.

Bob, a native of Sylvania, Georgia, spent his early years in Savannah. He was a graduate of Clemson University and of the Medical College of Georgia. He was in general practice in Valdosta for some 10 years before returning to residency training in pathology at Duke University. From 1958 until his death, he practiced pathology in Brunswick.

From the beginning of his career, he was active in organized medicine. During the Valdosta years, he was a member and a president of the South Georgia Medical Society. In Brunswick, he was a member and a president of the Glynn County Medical Society. He served the Medical Association of Georgia as a vice-councilor, councilor, president-elect, and from April 1977 until his death, as president.

Bob served the public also, as a Brunswick city commissioner for a term in the 60s and as a member of the Glynn County Board of Health for a number of years.

Bob was a unique individual. He spoke from deep conviction with a voice which commanded attention. He was vitally interested in the future of medicine and devoted many years to working for its improvement in our state and nation. He was a strong man, firm in his convictions and dedicated to his beliefs, which were conservative in approach. His deepest desire was the preservation of the rights of the individual physician and the individual patient. He abhorred the increase of governmental intervention into the relationship between the physician and his patient.

Bob believed that only by supporting and acting through established medical organizations could any physician hope to survive the onslaughts of governmental and other forces seeking to intrude themselves between the physician and his patient. He was, therefore, a strong advocate and an active member of MAG, AMA and his specialty organizations. His strong convictions and feelings about the worth and importance of organized medicine have influenced greatly many of his colleagues and have led a number of them to follow him into greater activity and involvement in county, state and national medical organizations.

To those who had the privilege of working with him daily, he was a firm friend and a valued adviser, able to draw equally upon his experience as a clinician and his knowledge as a pathologist.

Bob's leadership and influence will be sorely missed by the organizations in which he was active, as will his friendship, his counsel, and his wisdom by those who worked with him day by day.

Joe C. Stubbs, M.D.
Chairman, MAG Board of Directors
and
M. A. Glucksman, M.D.
Alternate Director, Brunswick

Operation Catch-Up

"AN OUNCE OF PREVENTION is worth a pound of cure." The truth of this old adage is most evident in the case of immunization of children against infectious diseases. Prior to polio vaccine, as many as 50,000 cases of, and 3,000 deaths from, poliomyelitis were reported in a single year. In 1964, a rubella epidemic resulted in a staggering economic cost of $1.5 billion. A ten-year survey of the benefits of measles vaccination in the U.S. revealed 23 million cases of measles averted with an estimated economic benefit of $1.3 billion.

Despite this great progress, every method of calculation that can be used has demonstrated that immunization levels against poliomyelitis, measles, rubella, mumps, diphtheria, pertussis and tetanus in this country's children are dangerously low. Responsibility for the present lag in immunizations, with the threat of epidemics, must be shared by private and public sectors of medicine as well as society as a whole.

Prompted by declining levels of immunization in 1973, the CDC, along with the Academy of Pediatrics and other interested groups, mounted a national campaign, Immunization Action Month, which resulted in substantially improved immunization levels in 1974 and 1975. In 1976, a group of task forces was appointed by HEW to study all of the problems of immunization and formulate policy recommendations for future immunization programs. In April 1977, President Carter launched "Immunization Initiative," a major national campaign, funded with $23 million for 1978. The program will be coordinated by the Secretary for Health of DHEW and the CDC, enlisting the support of all segments of American society, with two stated goals: to raise the level of children completely immunized against preventable childhood diseases to over 90% by October 1, 1979, and to establish a permanent system, involving state and local health departments, private physicians and voluntary organizations to ensure that all babies born each year are fully immunized at the earliest possible date.

Georgia is the first state to announce a major immunization campaign, officially proclaimed "Operation Catch-Up" by Governor Busbee, with a goal of increasing the level of immunity in Georgia children to 86% by December 1978. Coordinated by the Division of Physical Health of DHR, "Operation Catch-Up" includes several features: massive involvement of volunteers; an intensive education and publicity effort; survey for target areas; immunization teams and follow-up.

MAG and the Georgia Chapter, Academy of Pediatrics, endorse "Operation Catch-Up" and are represented on its advisory committee. The Academy of Pediatrics approved a policy, also approved by the AMA, listing the following components that should be required of any national immunization program:

(1) children should receive vaccines in a continuing and ongoing program, with vaccination as part of a total preventive health program and part of a continuing physician/patient relationship; (2) no financial barrier; (3) use of existing public and private systems of reimbursement; (4) immunity of personnel administering vaccines and manufacturers from adverse reactions occurring through no fault of the procedure; (5) multi-media promotional campaign to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion; (6) institution of an efficient record keeping system.

Hopefully, all primary physicians will cooperate when appoached to help in "Operation Catch-Up" and the children of Georgia will derive much more than a pound of cure from each ounce of prevention.

Marvin L. Davis, M.D.
Chairman, Infections Committee
Georgia Chapter, Academy of Pediatrics

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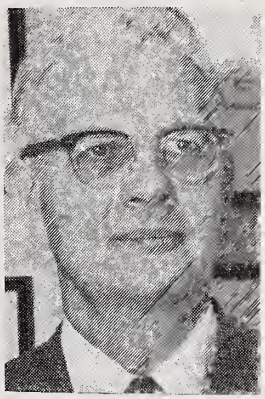
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president's letter



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Bob Perry

PERHAPS THE SADDEST DUTY to befall me has been to assume the presidency because of the sudden and untimely death, on December 30, 1977, of Robert E. Perry Jr., M.D., president of the Medical Association of Georgia.

Bob Perry was an outstanding man, professionally, personally and as our president. He was an energetic activist for the cause of private medical practice and the preservation of quality private medical care for the citizens of our state. All those who knew him personally can testify that he was a tireless leader in the cause of organized medicine.

He was born in Sylvania, Georgia, in 1921 and was a graduate of the public schools of Savannah. Undergraduate training was obtained at Clemson College, and he was graduated from the Medical College of Georgia in 1944. He was an outstanding scholar as attested by his membership in Alpha Omega Alpha Honorary Fraternity. After internship, he practiced family medicine from 1945-54 in Valdosta, Georgia. Pathology training was at Duke University. He practiced his specialty in Brunswick from 1958 until his death.

In organized medicine, he served as president of the South Georgia Medical Society and, later, as president of the Glynn County Medical Society.

In the Medical Association of Georgia, he served as vice councilor, councilor, chairman of council, president-elect and president—with great distinction.

He had been active in the Rotary Club, as a city commissioner and in the Protestant Episcopal Church.

All of us in the MAG family mourn his passing and will sorely miss his leadership.

Our deepest sympathy is extended to his wife, Alice Carol, his five children and all of his family.

In summary of the life of Robert E. Perry Jr., one can ask, "How could any man do more?"

There is no answer.

Sincerely,

Milton I. Johnson, M.D.

Milton I. Johnson, M.D.
President, Medical Association of Georgia

I've told this before . . .

(Editor's note: A halfway thorough job turned out to be most embarrassing for a young Dr. McDaniel in this story shared by a wiser Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Egoism Deflated

In the year of our Lord 1929, I was an assistant resident at the University Hospital in Augusta. There were two of us and one would be chosen for resident the following year.

We had very few specialists. The general surgeon took care of all the surgery, including fractures, gynecology, neuro- and lung surgery. He did cystoscopies and urological surgery.

The assistant resident in surgery was assigned all fractures for six months of his tour of duty. It was my lot one Saturday night to see this elderly slender black man who had been struck by a car. The driver said that he was not going very fast and that only his bumper hit him and knocked him down. A policeman had seen the accident, called the university ambulance and verified the driver's story.

He was complaining of severe pain in his left leg, just below the knee and repeatedly stated that he was all right everywhere else. A fairly thorough examination confirmed his statement. The only thing that I could find was a comminuted fracture of the tibia and fibula where the bumper struck him just below the knee.

With the help of a little morphine, a good orderly and nurse, I was able to mold the fracture and put on a plaster cast from mid-thigh to toe. After the plaster dried, we took an X-ray picture to be sure that the reduction was satisfactory. I viewed that picture a long time with increasing admiration. There was no way that the pieces of the tibia could have been fitted together more perfectly. The ends of the fibula were in excellent alignment.

Dr. Ralph Cheney was chief of surgery and I knew that he would be down the next morning about 10 o'clock to make rounds and I made a point to have that film by the old man's bedside.

When we came to him, I briefly reviewed what had happened, bared the cast on the old man's leg. Dr. Cheney looked at it, and before he could ask, I handed him the film. He looked at it for a good long time, said nothing. He was slow about handing out compliments, but I could tell that he was well pleased. I facetiously remarked that this would be a good case to present to the executive committee when they were choosing the resident. He did not say anything, nor did I expect it. Regardless of that I felt real good.

As we were leaving, the old man said to me, "Doc, you know my other leg has been hurting me some this morning." Dr. Cheney was on that side of the bed and lifted off the sheet. Sure enough, there was a little swelling just below the knee. Dr. Cheney palpated it, then turned to me. I did the same and much to my chagrin there was marked crepitation over the fibula—a definite fracture of the small bone in the other leg that I had overlooked.

After we had finished rounds and Dr. Cheney was leaving, he turned to me and said, "Oh, by the way 'Mac,' I don't believe I'd present that case to the executive committee!"

J. G. McDaniel, M.D.
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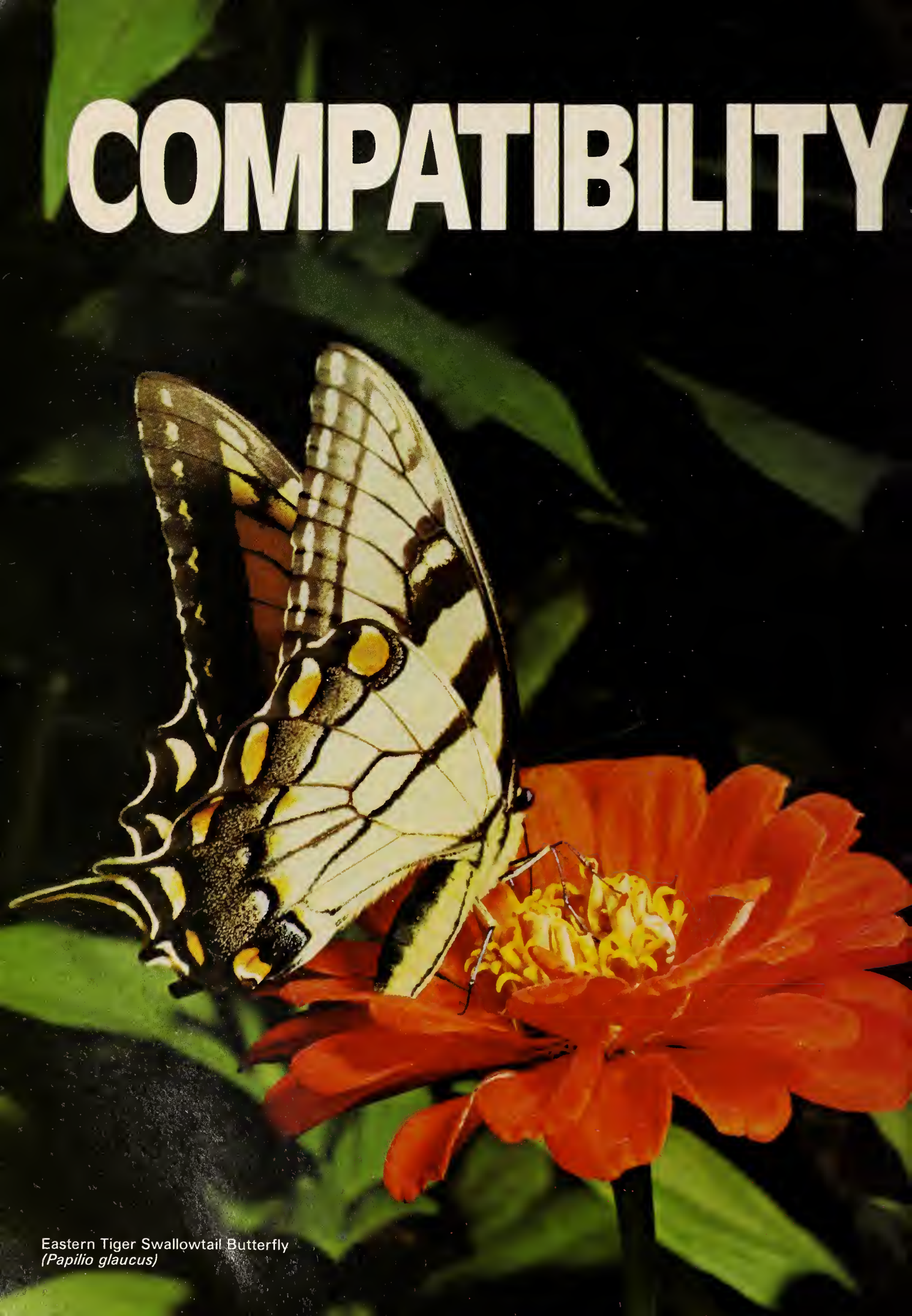
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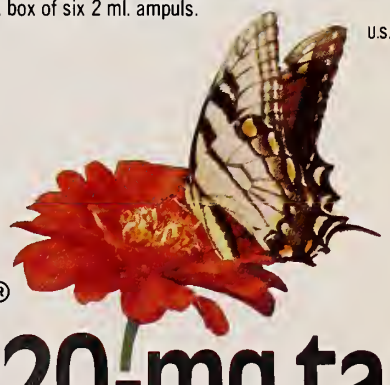
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heart page
heart page
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An Everyday Approach to an Everyday Problem

J. BRUCE CARR, M.D., *Columbus**

THE INCIDENCE OF HYPERTENSION is so large in our society that no physician, whether primary care or specialist, is free from dealing with the disease daily. Hypertension can occur with most any other disease state and may complicate the recognition and treatment of those other diseases. Hypertension will in itself, if left untreated, lead to serious and fatal complications in vital organ systems.

The need for and the efficacy of treatment of severe and moderate hypertension is no longer in doubt. There is also a trend to be aggressive in the monitoring and treatment of mild, uncomplicated hypertension.

There are a multitude of pharmacological agents available to treat hypertension. The success is dependent upon the patient being compliant in his use of medications and change of lifestyle. His physician must be knowledgeable in choosing the medications and dosage regimen to be followed.

Antihypertensive therapy depends on modifying specific physical parameters which determine blood pressure. Since the cardiovascular system is a closed hydraulic system, the physical principles of any such system apply. The simplest of these, in a static sense, is that pressure is dependent upon volume times the inverse of the compliance ($P = \text{volume} \times \frac{1}{\text{compliance}}$). In a dynamic sense, it is dependent on flow (cardiac output) times resistance ($P = \text{cardiac output} \times \text{resistance}$). To change pressure, either resistance, compliance, volume and/or flow must be changed.

Current acceptable approaches to therapy of noncomplicated primary hypertension include drugs which are directed to one or more of these parameters so that blood pressure is lowered to normal or near normal levels with the least expense, trouble and side effects for the patient.

The classical mainstay and first line of therapy in the treatment of hypertension is thiazide diuretics. They act first and most rapidly to produce a reduction in total

* Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

Dr. Carr's address is 2300 Manchester Rd., Columbus, Ga. 31904.

body salt and water, therefore decreasing vascular volume. A more important and a lasting effect of thiazides is a decrease in vascular resistance via primary arteriolar vasodilatation.

Thiazides are administered daily or twice daily in one to three times the base dose (500-1500 mg. chlorothiazide, 50-150 mg. hydrochlorothiazide, etc.). The more important side effects are allergic hypersensitivity, induction or exaggeration of glucose intolerance, increasing hyperuricemia, hypercalcemia and hypokalemia.

Most cases of mild essential hypertension will respond to thiazide diuretics. However, moderate and severe hypertension will almost always require the administration of other antihypertensive agents. With failure to achieve adequate control in the essential hypertensive patient with adequate doses of thiazides, the physician must then decide how to change the regimen to achieve optimum control. Alpha-methyldopa (Aldomet), clonidine (Catapres), propranolol (Inderal), hydralazine (Apresoline) and prazosin (Minipress) are those from which the logical choice is then made.

Methyldopa and clonidine act in a similar fashion by decreasing central nervous system sympathetic outflow, thereby resulting in less resistance and more compliance in the vascular system. Methyldopa may further have an effect by resulting in the formation of the false transmitter alpha-methylnorepinephrine at the sympathetic nerve endings. Both are effective antihypertensives.

Methyldopa is administered in doses of 500-3000 mg. per day, the usual being 1000-2000 mg. Side effects include drowsiness and lethargy, but these usually improve after two to four weeks. Impotence seems to be the greatest problem amongst males. Dry mouth is common. Orthostatic hypotension occurs and is relieved by decreasing the dose. Many patients develop a positive Coomb's test which rarely progresses to hemolysis. Various degrees of hepatitis occur, requiring discontinuation of the drug.

Clonidine is a newer agent available in 0.1 and 0.2 mg. tablets. The usual dose is 0.8 mg. per day with a range of 0.4-2.4 mg. Its main side effect is severe dryness of the mouth. Onset of action is rapid (2-4 hours) and allows for rapid control of blood pressure. Its major negative characteristic is rebound hypertension upon withdrawal, occasionally becoming of great clinical significance, thereby making it a poor choice for the patient likely to be undependable or noncompliant.

Propranolol is a beta-adrenergic blocker which decreases blood pressure primarily because of its negative inotropic and chronotropic effects on the heart with resultant drop in cardiac output (flow). It may also importantly have the effect of decreasing renin secretion, which via that negative influence on the renin-angiotension system would result in less vasoconstriction (resistance).

Antihypertensive doses of propranolol range from 40-640 mg. per day with the usual being about 160 mg. It uncommonly has side effects. Those occurring include lethargy, impotence and dyspnea. The drug should not be used in patients using insulin or subject to hypoglycemia, inasmuch as it blocks the normal sympathetic reaction to hypoglycemia. It likewise cannot be used in patients with bronchoconstrictive disease. It must be used cautiously in patients with congestive heart failure.

Hydralazine and prazosin demonstrate effects which are independent of the autonomic nervous system. Both are effective primary arteriolar vasodilators.

Hydralazine is administered in doses of 40-400 mg. per day, the usual being 100-200 mg. When used alone, it may have severe side effects of pounding headache, chest pain, flushing, nausea, general feeling of ill being and tachycardia. However, these side effects rarely occur when hydralazine is used in conjunction with propranolol. Hydralazine must be used cautiously in patients with arteriosclerotic heart disease, inasmuch as angina and rarely myocardial infarction can result. When used in doses of greater than 200 mg. per day, there is danger of developing a clinical picture nondistinguishable from lupus erythematosus.

Prazosin is a newly marketed antihypertensive agent which is administered in doses of 2-20 mg. per day. It has no significant side effects reported to date with the exception that occasionally the first dose can result in severe orthostatic hypotension.

It is generally agreed that after thiazide failure, the next step is the addition of another agent to the thiazide, rather than mere substitution. According to the patient's condition and the physician's experience, any other agent may be used. Perhaps the most reasonable would be methyldopa, clonidine or propranolol. Whatever is chosen, it should be administered in adequate doses and probably with any of the above mentioned agents, four times per day until the amount needed is determined. The dosage schedule can subsequently be decreased to two or three times a day if a good result is accomplished.

It is a positive selling point of drug manufacturers that their drug may be administered only two or three times a day; however, because of the relatively short half lives of the above medications, except the thiazides, it seems reasonable to institute therapy with these agents at a dosage schedule of four times per day.

Should a two-agent regimen be a failure, it is certainly indicated to consider that the patient may have a secondary form of hypertension. Serum creatinine, serum electrolytes and an IVP should be done. The physician should give serious consideration to the need for plasma renin and urinary catecholamine determinations. Pertinent history and physical should be repeated.

In the absence of a primary cause of hypertension and complication, one then faces the need for additional agents. It is important to remember that in the noncompliant patient, no amount of drug changes will result in good control; however, most patients will respond positively with proper emphasis placed on the fact that it is his disease and nothing except careful diet and medication will control the disease.

A successfully tried regimen in the more resistant hypertensive is the combination of propranolol and hydralazine in association with a diuretic agent. One may wish to use either of the loop diuretics, furosemide or ethycrinic acid, rather than a thiazide, especially if the patient has continued to use sodium excessively or if he has any degree of renal insufficiency. A 24-hour urine can be done to ascertain the patient's sodium intake and excretion.

When propranolol and hydralazine are used together, the usual dose is 20-80 mg. of propranolol and 25-50 mg. apresoline every six hours. With failure, methyldopa also could be added to this regimen.

However, should a patient be on adequate doses of propranolol, hydralazine and methyldopa or any other such combination and remain hypertensive, it should be *prima facie* evidence of unrecognized noncompliance, complications or primary disease and the patient should be hospitalized for investigation and appropriate consultation.

The treatment of hypertension is often not very satisfying or dramatic for the patient or the physician, especially with regards to noncompliant and disinterested patients; however, with proper instruction and adequate attention, enormous service is rendered to a great number of people.

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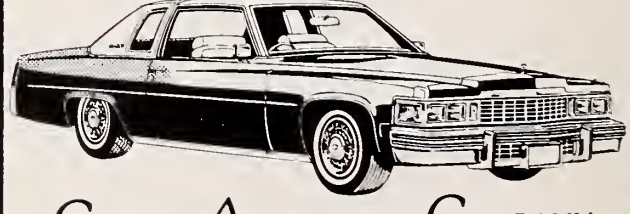
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Rural Health Clinic Services Bill

ROBERT N. BERG, *Atlanta**

PRESIDENT CARTER RECENTLY signed legislation designed to preserve the financial vitality of health care clinics located in rural areas and staffed by non-physician personnel providing primary and emergency health care services.[1]

Many isolated rural communities, unable to attract or support the practice of a physician, have come to rely on other types of primary and emergency care services. In most cases, these services are provided by clinics which are staffed by nurse practitioners and physician assistants who are specially trained to provide primary medical care services traditionally provided by physicians. However, while the medical services provided by these nurse practitioners and physician assistants are of the type ordinarily performed only by physicians, and would be eligible for reimbursement under Medicare or Medicaid if performed by a physician, these services were previously not eligible for reimbursement when provided by nurse practitioners and physician assistants, except when they were provided "as an incident to a physician's service."[2]

This distinction between services by a physician and the same services by non-physician personnel has created serious financial problems for the isolated communities, since most services provided by non-physician personnel were not reimbursable under Medicare or Medicaid and thus often resulted in bad debts to be written off by the clinic providing the services.[3] The resulting financial unattractiveness inhibited the establishment of new clinics and hindered the improvement of rural health care generally.

To combat these problems, Congress passed the "Rural Health Clinic Services Bill" which is divided into four major areas: (1) Medicare amendments; (2) Medicaid amendments; (3) demonstration projects for physician-directed clinics in urban medically underserved areas, and (4) report by the Secretary of Health, Education and Welfare (HEW) on mental health and other centers.

Medicare Amendments

Section One of the bill provides that "rural health clinic services" are eligible for reimbursement under Medicare when such services are furnished to an individual as an outpatient of a "rural health clinic." In that context, "rural health clinic services" (in addition to physicians' services, etc.) include (1) services provided by physician assistants and nurse practitioners and incidental services and supplies furnished by them, provided that these services and supplies would be covered if furnished by a physician, and further provided that the physician assistants or nurse practitioners meet certain training, educational and experience

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

requirements and (2) part-time or intermittent nursing care and certain related medical supplies furnished by registered professional nurses or licensed practical nurses to homebound individuals in areas where there is a shortage of home health agencies, if such care is pursuant to a written plan established by a physician, physician assistant or nurse practitioner, and is subject to periodic review by a physician.

To be eligible for reimbursement, "rural health clinic services" must be furnished in connection with a "rural health clinic." In order to qualify, a facility must be in a "rural" area, defined as any area not classified as "urbanized" by the Bureau of the Census.[4] Secondly, it must be located in a "medically underserved" area, defined as an area designated by HEW as either a "personal health services shortage" area or as a "health manpower shortage" area.[5]

A "rural health clinic" must also meet several other requirements. Clinics that are not physician-directed must have an arrangement with one or more physicians to ensure that control of and responsibility over the operations of the clinic are maintained by a physician; alternatively, full-time physician-directed clinics must have a designated staff physician to perform the same activities that are accomplished through this type of arrangement. Additionally, a rural health clinic is required to maintain clinical records on all patients, maintain arrangements with one or more hospitals for referral or admission, provide routine diagnostic services, have available such drugs and biologicals as are necessary for emergencies, and maintain adequate procedures for utilization review.

Reimbursement for rural health clinic services must be related on a reasonable basis to the actual costs of the services. However, the bill gives to the Secretary of HEW the flexibility to develop an alternative cost-reimbursement system. Additionally, the bill authorizes the Secretary to make a one-year study of the feasibility of imposing a co-payment for each visit to a rural health clinic, instead of the Medicare deductible and coinsurance, if such a practice would result in lower administrative costs.

Medicaid Amendments

In general, the Medicare provisions of the bill are also applicable to Medicaid services; for example, a facility certified as a "rural health clinic" under Medicare is deemed to have satisfied the certification requirements under Medicaid. However, services offered by a clinic that are covered only under Medicaid are subject to the Medicaid reimbursement requirements.

Additionally, "rural health clinic services" must be covered by a state's Medicaid plan, and the state's plan must provide for 100% reimbursement of the cost for services reasonably related to the cost of furnishing those services. States in which legislative changes are necessary to comply with these requirements are given a grace period of one legislative session within which to enact appropriate legislation.

Demonstration Projects for Physician-Directed Clinics in Urban Medically Underserved Areas

While the eligibility for reimbursement under Medicare and Medicaid is limited to clinics located in "rural" areas, the bill also requires the Secretary of HEW to carry out demonstration projects in "urban medically underserved areas." These projects would involve reimbursement for services provided by physician-directed clinics in "urban medically underserved areas" on a cost basis and would include services provided by physician assistants and nurse practitioners.[6]

Report by Secretary of HEW on Mental Health and Other Centers

The Secretary of HEW is required to prepare a report for Congress, due six months after the enactment of the bill, on the feasibility of extending Medicare

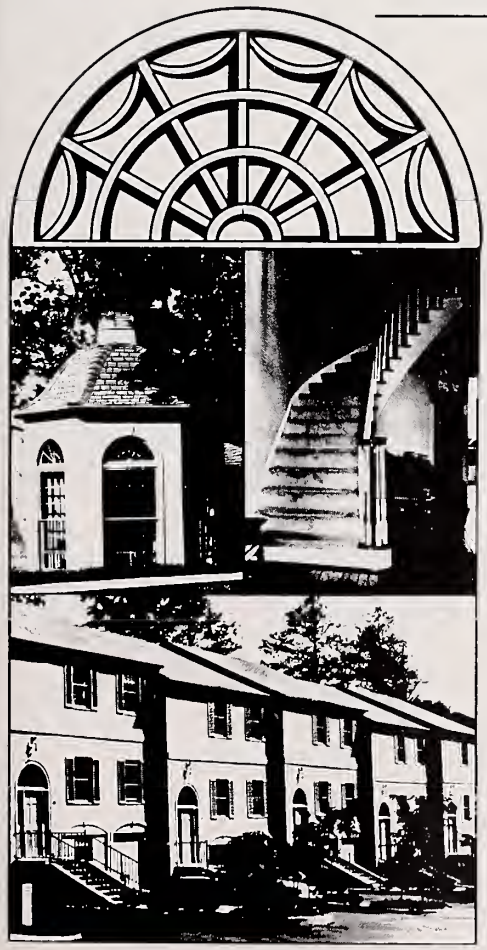
coverage to urban or rural comprehensive mental health centers and to centers for treatment of alcoholism and drug abuse.

The Potential Impact

The Senate Committee on Interstate and Foreign Commerce concluded that implementation of the bill should not result in an increase in program expenditures. Moreover, should any additional costs be incurred, the Committee expressed the view that these costs would be more than offset by improvements in the health status of the millions of Americans living in areas with a shortage of personal health services.[7]

NOTES

1. Public Law 95-210.
2. 42 U.S.C.A. §1861(s)(2)(A) defines these "incidental services" as including those services and supplies commonly furnished in physicians' offices and commonly either rendered without charge or included in the physicians' bills.
3. Report by the House Committee on Ways and Means, July 29, 1977.
4. In Georgia, the following areas are classified as "urbanized" by the Bureau of the Census: Albany, Atlanta, Augusta, Chattanooga (Walker County), Columbus, Macon and Savannah.
5. The terms "personal health services shortage area" and "health manpower shortage area" are defined in Sections 1302(7) and 332(a)(1)(A) respectively of the Public Health Services Act. However, the Bill includes a savings provision whereby a clinic located in an area designated as a "medically underserved" area will remain eligible for reimbursement should the area subsequently become redesignated, and also includes a provision allowing any private, non-profit clinic in operation on July 1, 1977, in a "medically underserved" rural area to satisfy the definition of a "rural health clinic."
6. The Bill does not specify whether the demonstration projects are intended to include all physician-directed clinics in all urban medically underserved areas or merely a sample of clinics to provide the Secretary with data sufficient for a complete evaluation.
7. Report by the Senate Committee on Interstate and Foreign Commerce, September 19, 1977.

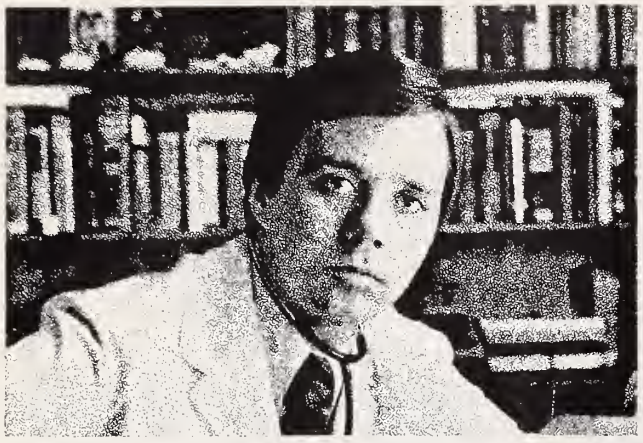


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YOU'VE STUDIED HARD TO BE A DOCTOR. BE A DOCTOR.

The U.S. Navy can offer you the kind of practice you studied so hard for. Devoting your time solely to the practice of medicine.

As a Navy physician, we'll give you a challenging and rewarding practice—a practice with a minimum of paperwork and no administrative overhead. It's a practice complete with excellent facilities and support personnel.

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BE THE DOCTOR YOU WANT TO BE.
IN THE NAVY.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



Anxiety...
Often a significant feature of irritable bowel syndrome*

The action of Librium®
(chlordiazepoxide HCl)

A significant advantage of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

ROCHE

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954**, followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

1954
1978

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

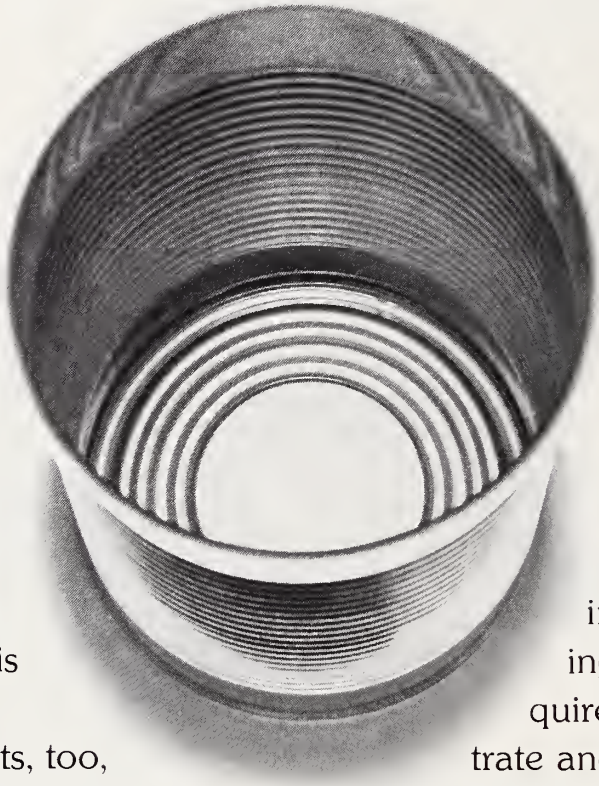
In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

NOW a two-piece 14oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modified to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac—formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products.**



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(714) 785-2444

Eastern U.S.
LOMA LINDA FOODS
13246 Wooster Road
Mount Vernon, OH 43050
(614) 397-7077

Loma Linda®

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens



□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

□ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

*Nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

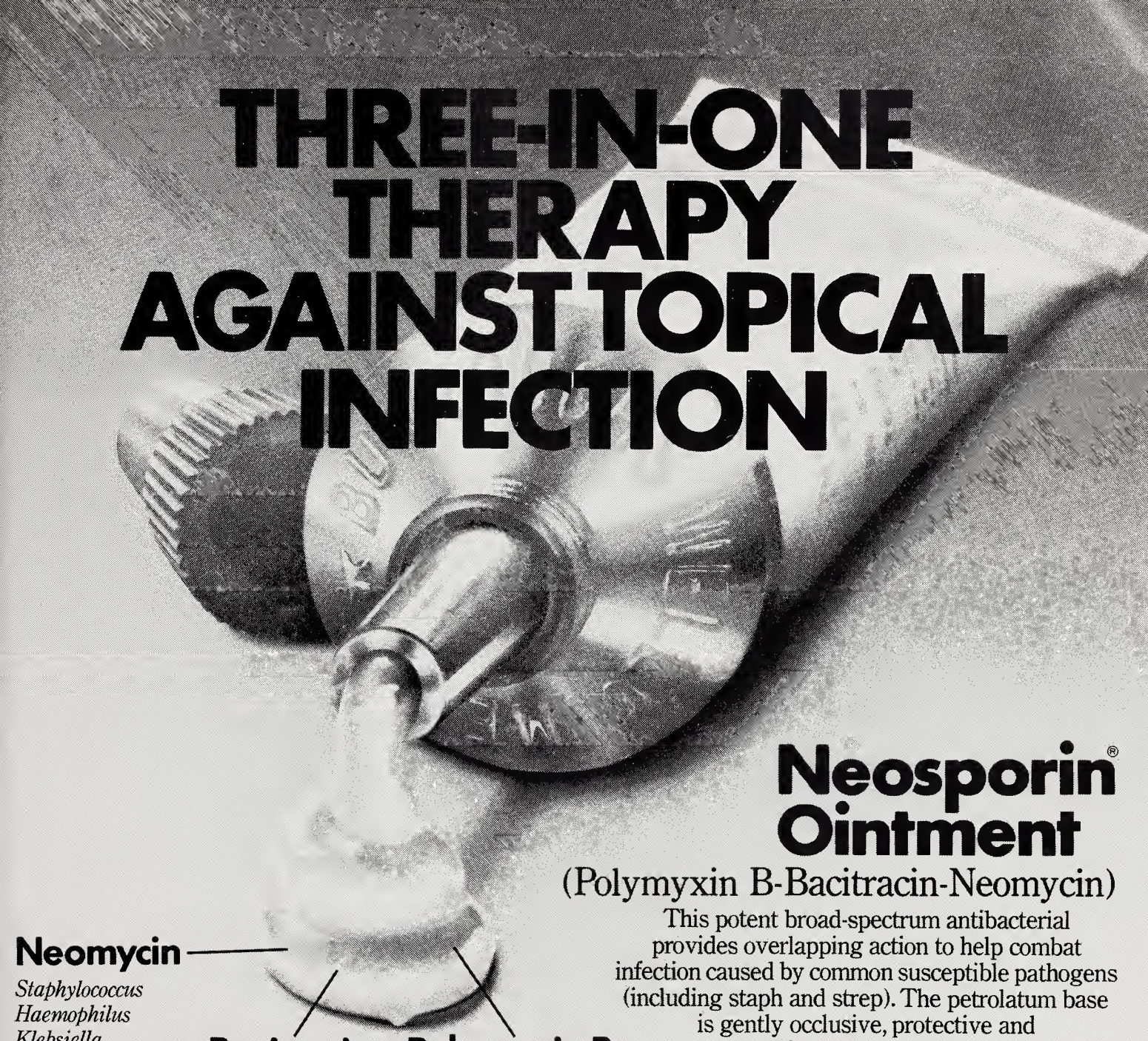
Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

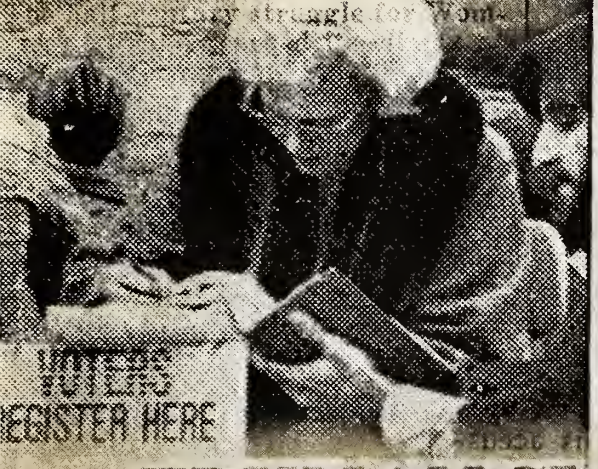
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the m "the cornerstone in a str which is being built for m means comple

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
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DiSantis, Dennis E., DeKalb—N1—GE
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Lerman, Bernard, MAA—Act—GS
5650 Old National Hwy., College Park 30349

Marascalco, Robert J., Muscogee—N2—ORS
105 Physicians Bldg., Columbus 31902

McCann, Sandra Briggs, Muscogee—Act—R
P.O. Box 2787, Columbus 31902

Mills, Marvin Lean, W-C-D—N2—IM
Ste. 300, 150 Gross Crescent Rd., Fort Oglethorpe 30742

Osmon, Carlos A., Cobb—N2—IM
3949 South Cobb Dr., #107, Smyrna 30080

Polhill, James B., Jefferson—N2—FP
Jefferson Hospital, Louisville 30434

Reddy, Sudhakara, Ogeechee River—Act—PD
112 Savannah Ave., Statesboro 30458

Termotto, David Walter, Cobb—N2—AN
3530 Briarcliff Rd., N.E., Atlanta 30345

Tidwell, Thomas Jackson, Whitfield-Murray—N2—OS
Radiotherapy Dept., Hamilton Memorial Hospital, Dalton 30720

Wade, Thomas Andrew Jr., Muscogee—N2—IM
110 Doctors Bldg., Columbus 31901

SOCIETIES

The **Medical Association of Atlanta** has elected officers for 1978. They are: Charles E. Harrison Jr., M.D., president; William C. Collins, M.D., president-elect; Bob G. Lanier, M.D., treasurer; Russell C. Chambers, M.D., junior trustee, and Jeffrey T. Nugent, M.D., trustee-at-large.

Dearing A. Nash will serve as president of the **Georgia Medical Society** during 1978. Other officers for the coming year for the society are: J. Robert Logan, president-elect; John B. Raum, vice-president; Eloise B. Sherman, secretary, and J. Lane Reeves, M.D., treasurer.

The **Muscogee County Medical Society** also elected officers for 1978. They are: Bruce C. Newsom, M.D., president; E. M. Molnar, M.D., president-elect, and Kenneth L. Goldman, M.D., secretary-treasurer.

The **Tri-County Medical Auxiliary** has awarded $250 scholarships to Cynthia Susan Gresham of Bowdon and Jo Alese Ridley of Carrollton. The scholarships are given each year to area high school students who plan to enter the allied medical careers field.

PERSONALS

First District

Lester M. Haddad, M.D., director of Education in Emergency Medicine at Memorial Hospital in Savannah, has been appointed Chairman of the National Committee on Toxicology of the American College of Emergency Physicians for 1978.

Sylvania physician **Ivey L. Shuman, M.D.,** has been named a member of the Committee on Maternal and Infant Care of the Georgia Academy of Family Physicians.

Second District

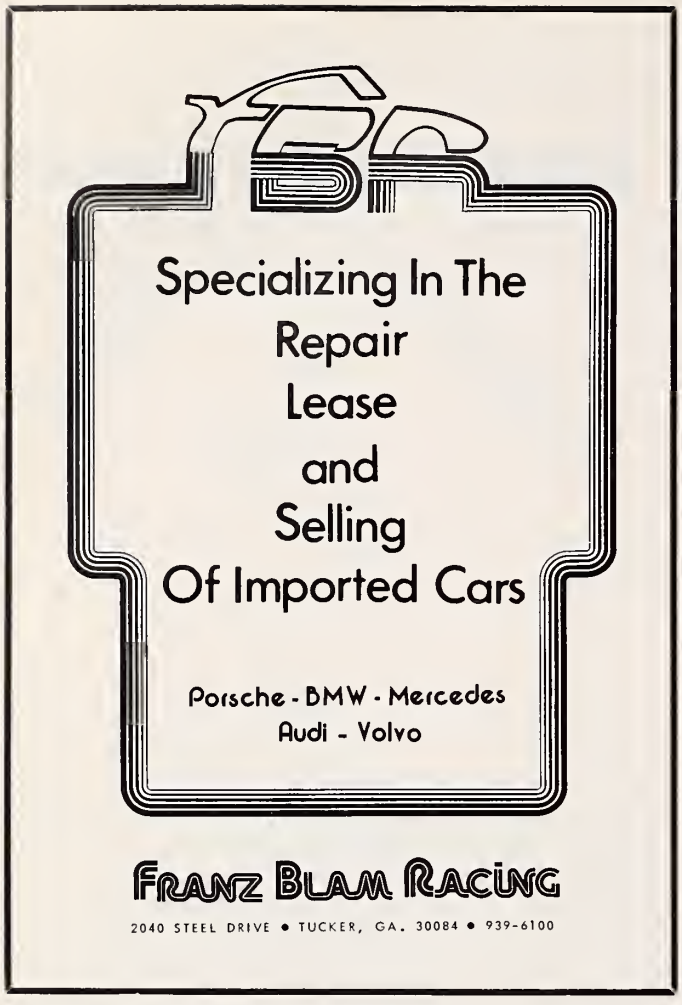
The Georgia Heart Association presented to **James H. Crowdis, M.D.,** of Blakely, a Distinguished Service Medallion at a Rotary Club meeting in December. The award was given to Dr. Crowdis because of his outstanding efforts on behalf of the Heart Association.

Jesse D. Hester, M.D., of Tifton, has been elected to fellowship in the American College of Obstetricians and Gynecologists.

Thomasville physician **Charles Watt Jr., M.D.,** gave a lecture in November on snakebites and first aid treatment for them. The lecture was sponsored by the Pelham Jr. Woman's Club.

Third District

A. S. Batts, M.D., of Hawkinsville, was presented the Hawkinsville Lions "Outstanding Citizen Award of 1977" at their annual Christmas banquet.



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Fourth District

Henry H. Boyter, M.D., of Columbus attended the Georgia-Florida Obstetrical-Gynecology meeting in Palm Beach, Florida.

Obstetrician and gynecologist **Allan J. Dinnerstein, M.D.,** of Jonesboro, has been named chief of staff-elect at Clayton General Hospital for 1977-78.

Forest Park surgeon **Clyde C. Harrison Jr., M.D.,** has been named chief of staff of Clayton General Hospital for 1977-78.

Andy P. Morley, M.D., of Decatur, was named a fellow of the American Academy of Family Physicians.

T. A. Sappington, M.D., of Thomaston, has been awarded the Distinguished Service Award of the Georgia Academy of Family Physicians.

Fifth District

Carl C. Jones, M.D., of Atlanta, has been awarded the 1977 Aven Cup, an award of the Medical Association of Atlanta for outstanding public service by a member.

Sixth District

Macon physician **Milton I. Johnson, M.D.,** has been named president-elect of the Georgia Academy of Family Physicians.

Hoke Wammock, M.D., of LaGrange, has been named the Medical College of Georgia's Sesquicentennial Alumni Ambassador during the college's 150th celebration in 1978.

Seventh District

Carlos Selmonosky, M.D., of Austell, was the key speaker at a community service program on chronic lung diseases held in November at Cobb General Hospital.

Rome physician **Joel Todino, M.D.,** participated in a panel discussion in December at Shorter College on "Science and Ethics."

Eighth District

William A. Hitt, M.D., of St. Simons Island, was named a fellow of the American Academy of Family Physicians.

Jesup physician **Ollie O. McGahee Jr., M.D.,** was one of four Georgia doctors to receive a national committee assignment with the American Academy of Family Physicians. Dr. McGahee will serve on the Committee on State Chapter Affairs.

Douglas physician **Tommy K. Stapleton, M.D.,** also was one of four Georgia doctors chosen to serve in a national capacity with the American Academy of Family Physicians. Dr. Stapleton will serve as the AAFP's representative to the AMA's Joint Review Committee for Accreditation of Programs Educating Physicians Assistants.

Tenth District

Jon C. Calvert, M.D., of Augusta, has been appointed to the Committee on Clinical Investigation of the American Academy of Family Physicians.

Preston L. Wilds, of the department of obstetrics and gynecology at the Medical College of Georgia, was one of two Georgia physicians to meet the requirements of

The American Board of Obstetrics and Gynecology for a Certificate of Special Competence in Maternal-Fetal Medicine.

DEATHS

James A. Elkins

James A. Elkins, M.D., 67, of Columbus, died December 22 at St. Francis Hospital. A native of Magazine, Arkansas, Dr. Elkins had practiced orthopedic surgery in Columbus since 1948. He was past president of the Muscogee County Medical Society and past chief of staff at the Medical Center.

Surviving are his wife, Mrs. Dorris Elkins, two sons and three grandchildren.

Luke G. Garrett Jr.

Luke G. Garrett Jr., M.D., of Austell, died December 9, at the age of 60. Dr. Garrett, who served as mayor of Austell for 12 years, was a graduate of Emory University School of Medicine and past president of the Cobb County Association for Retarded Children. He served as chief of staff of Cobb General Hospital for two years and was also chief of staff for Atlanta West Hospital for two years.

Surviving are his wife, Mrs. Gladys Elliott Garrett, two daughters, one son, one sister and two grandchildren.

Specialties Gain AMA Representation

National medical specialty societies will be able to participate directly in AMA policymaking at the 1978 Annual Meeting under a new AMA House of Delegates ruling.

At its Interim Meeting in Chicago in December, the House of Delegates voted to provide one delegate seat in the House to any specialty society that was represented on an AMA Section Council in 1977 and has at least 1,000 AMA members or represents a specialty for which there is an approved examining board listed in the Liaison Committee on Graduate Medical Education's Directory of Accredited Residencies.

Qualifying societies that apply for representation before the first day of the 1978 Interim Meeting will have their delegates seated at the Annual Meeting next June. Those applying later must be approved for representation by both the Board of Trustees and the House of Delegates.

The Section Councils will continue as official components of the AMA. At the 1978 Annual Meeting, the Section Councils will be composed of specialty societies represented in the House and representatives of other specialty societies recommended by the Section Councils and approved by the Board of Trustees. Specialty society delegates and alternate delegates will be members of the appropriate Section Council, but the Section Councils themselves will have no delegates.

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MAG Sponsors Student Attendance at AMA Meeting

As a part of its support of future doctors, each year MAG sponsors a program through which a medical student (or students) can attend an AMA meeting. This provides an opportunity for the students to get a good introduction to organized medicine. In December of 1977, Penny E. Petersen from MCG was selected to attend the AMA interim meeting in Chicago. Here is her report of the experience.

This fall, the American Medical Student Association chapters at the Medical College of Georgia and the Emory University School of Medicine each received an invitation to send a representative, as the guest of the MAG, to observe the proceedings of the AMA interim convention in Chicago. Having been very curious about the AMA—what it does, how it operates, who participates—I immediately expressed my interest in going and was chosen as the representative from the Medical College.

In retrospect, my departure was only appropriate for what was to come. Taking my pathology final six days early, I finished within an hour of my plane's departure time. Arriving at the airport with five whole minutes to spare, I settled in to relax on the plane and discovered that the dean of my medical school was seated in the row behind me.

On Saturday, December 3, much of the Georgia delegation arrived. After narrowly escaping being registered with the AMA Women's Auxiliary instead of with the AMA convention itself, I finally found myself properly name-tagged, checked-in, registered, and scheduled, and began to meet the rest of the folks from Georgia.

Coming as part of the state delegation enabled me to participate in the convention at two levels: that of the state delegation to the convention, and that of the Student Business Section (SBS) of the AMA. The SBS met Sunday morning and much of Sunday afternoon. Topics discussed included medical specialties, the AMA's National Health Insurance bill, the Bakke case, the restructuring of the SBS, and state and national legislation concerning medical students.

Of great concern to medical students now are the several bills which have been introduced in various state legislatures (including those of Kansas, West Virginia, South Dakota, and California) concerning mandatory service or practice within the state for students attending the state medical schools. The lengths of service time proposed in these bills range from one or two years, to one year of service per year of attendance at the state medical school, to ten years of service. Some of these bills would allow students to reimburse the state for the estimated cost of their medical education in lieu of serving (e.g., in one such bill, the student would be required to either serve one year or pay the state $12,500 for each year of attendance at a state medical school). Other bills don't offer the alternative of reimbursement to the state; every student in the state medical schools would serve, with no exceptions. The mandatory service bills also vary in that some would allow the student to select a community from a list furnished by the state, while in others the state would dictate where the student would serve.

Unsurprisingly, the majority of medical students are against these bills in general, but for various reasons. Many dislike strongly any limitation of the freedom of where to establish a practice. Some think that allowing students the option of service or reimbursement to the state would furnish the wealthy with a loophole (they could "buy" their way out of service), while the less fortunate would be obligated to serve. Other students expressed the following: Why should only doctors be singled out? What about other health care professionals and paraprofessionals? And, for that matter, all students attending state universities and professional schools have their educations partially subsidized by the state. If the rationale for these bills lies in the argument that the state subsidizes its medical students' educations and therefore is owed a debt, then why aren't all students in state schools asked to serve in some way or to reimburse the state for their educational costs?

As the above views were expressed, the discussion naturally led to the problem of maldistribution, to which these bills are purportedly addressed. Are there other possible solutions to this problem besides mandatory service? And, if so, can these solutions be found and implemented without government intervention?

Monday, December 5, was spent in reference committee hearings. The resolutions submitted to the House of Delegates were designated by subject matter to be considered by a specific committee. Each committee then heard testimony from anyone who wished to express an opinion on a resolution before that committee. The submitted resolutions dealt with everything from national health insurance to quackery to a study concerning the prevention of atherosclerosis (people who have two drinks a day were found to be the most free from atherosclerosis). The opinions on these matters likewise ran the gamut. What struck me immediately about these hearings was how very odd it was to watch physicians, usually reticent to blatantly disagree with their colleagues' opinions, arguing vehemently in public.

Discussion of the AMA's national health insurance bill waxed for hours and provided me with some of my most vivid impressions of the hearings. Many speakers found the argument for having a bill "in the hopper" in order to gain a seat at the bargaining table when the "inevitable" NHI is drafted, to be a fallacious one. One speaker compared it to choosing one's own form of strangulation—à la Congress or with the AMA meth-

od. One of the Georgia delegates spoke along these lines. The speaker following him was a delegate from California who proceeded to relate that he had written his senator and had just received a personal response assuring him that if the AMA withdrew its NHI bill, it would seriously jeopardize its position at the bargaining table. The Californian concluded with, "So who are you going to believe, a 'small-town' doctor from south Georgia or a U.S. Senator?" The response was immediate and decisive by the doctor.

After listening for awhile, it struck me that those who spoke in favor of the bill emphasized its necessity if we were to have a say when NHI did come about. During over two hours of discussion, only one person said that he supported the bill because he supported the concept of health insurance for every American. In the final analysis, the reference committee hearings were truly a forum where freedom of speech was exercised.

Sunday afternoon, all day Tuesday, and Wednesday morning were spent in sessions of the House of Delegates. After Monday's hearings, each reference committee drew up a report containing recommendations for its committee's resolutions. In general, there seemed to be a tremendous resistance on the part of the House to not vote as the committees recommended, or even to amend in any manner the reference committees' reports. If there was discussion on a resolution, it was limited and subdued in comparison to Monday's hearings. The tone was businesslike, as we progressed from one reference committee report to the next, advancing one by one through the stack of resolutions. The pace of the proceedings accelerated as we approached Wednesday noon, as many had afternoon flights to catch and busy practices to resume.

I returned to Augusta Wednesday evening with many new ideas and new perspectives on old ideas. (I also returned to my finals, which were to continue on Thursday!) The convention was a very rewarding experience for me, and I wish to thank the MAG for making it possible. I hope I will be able to relate some of my experiences to my fellow medical students. For example, I was able to get an idea of the problems with which the AMA concerns itself, and how its internal structure works. I was able to give input into the SBS sessions and into the Georgia state caucuses. I met some of the people who participated in the AMA's decision-making process and was consistently impressed with their dedication to their practices and to their profession in general. I found the experience of communicating with these people extremely beneficial for a medical student to whom being established in a practice and within the medical profession seem so distant at times. I think that many other medical students would benefit from similar experiences. In light of this, I would like to conclude with the suggestion that the MAG and the future physicians of Georgia begin to increase their lines of communication and to strengthen their ties, to their mutual benefit.

Penny E. Petersen
Sophomore Medical Student
Medical College of Georgia

Dr. Johnson Becomes MAG President



FOLLOWING THE SAD AND UNTIMELY DEATH of Robert Perry, M.D., Milton I. Johnson, M.D., who was elected MAG first vice-president in 1977, assumed the presidency of the MAG.

Dr. Johnson, a family practitioner who also holds a degree in pharmacy, has held several offices in the MAG as well as in the Georgia Academy of Family Physicians. He has been vice-councilor, councilor, a member of the House of Delegates from Bibb County, and is now president-elect of the Georgia Academy of Family Physicians for 1978.

A native of Macon, Dr. Johnson was instrumental in the establishment of the Mercer University School of Medicine. He was appointed to the faculty position of Clinical Associate in 1974 and served on the Ad Hoc Committee to formulate by-laws for the school.

Dr. Johnson will continue as president of the MAG until April 1978, when president-elect Carson B. Burgstiner, M.D., will take over the responsibility.





COBB SYMPOSIUM '78: "THE HUMAN RESPONSE TO CHANGE"

THE 13TH ANNUAL COBB COUNTY SYMPOSIUM is scheduled to be held April 6-7 at Kennesaw College, with the closing dinner to be held at the Atlanta Hilton Hotel. The theme this year is "The Human Response to Change."

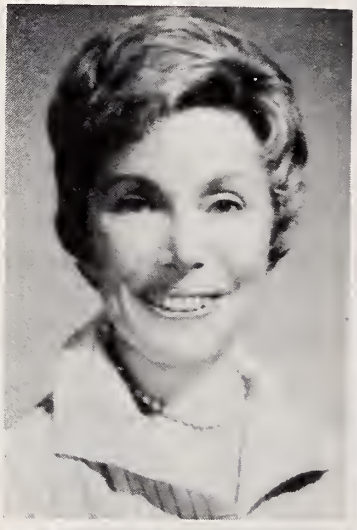
Among those appearing on the program are *Foxfire* editor and teacher Eliot Wigginton and Judge Phyllis Kravitch, the first woman in Georgia to be elected to the position of Superior Court Judge. Professor Wigginton will discuss "The Foxfire Story: Recovering a Sense of Past and Place—an Experiment in Education," and Judge Kravitch will discuss "The Human Response to Social Change and Law."

Other speakers and their topics include: Dr. Austin DesLauriers, of the Devereaux Schools, "On Love and Learning"; Dr. James A. Knight, dean of the College of Medicine at Texas A&M University, "The Human Response to Success and Failure," and Reverend Dr. Donald Shriver Jr., president of Union Theological Seminary in New York, "Theological Responses to Change."

Norman Cousins, editor of *Saturday Review,* will be the featured speaker at the closing dinner at the Atlanta Hilton on Friday evening.

The symposiums, initially started by the Cobb County Medical Society, now are co-sponsored by the medical society, its auxiliary, the Cobb County Bar Association, the Cobb County Ministerial Association and Kennesaw College.

For more information, write Symposium '78, Kennesaw College, Marietta, Georgia 30061 or call (404) 422-8770.

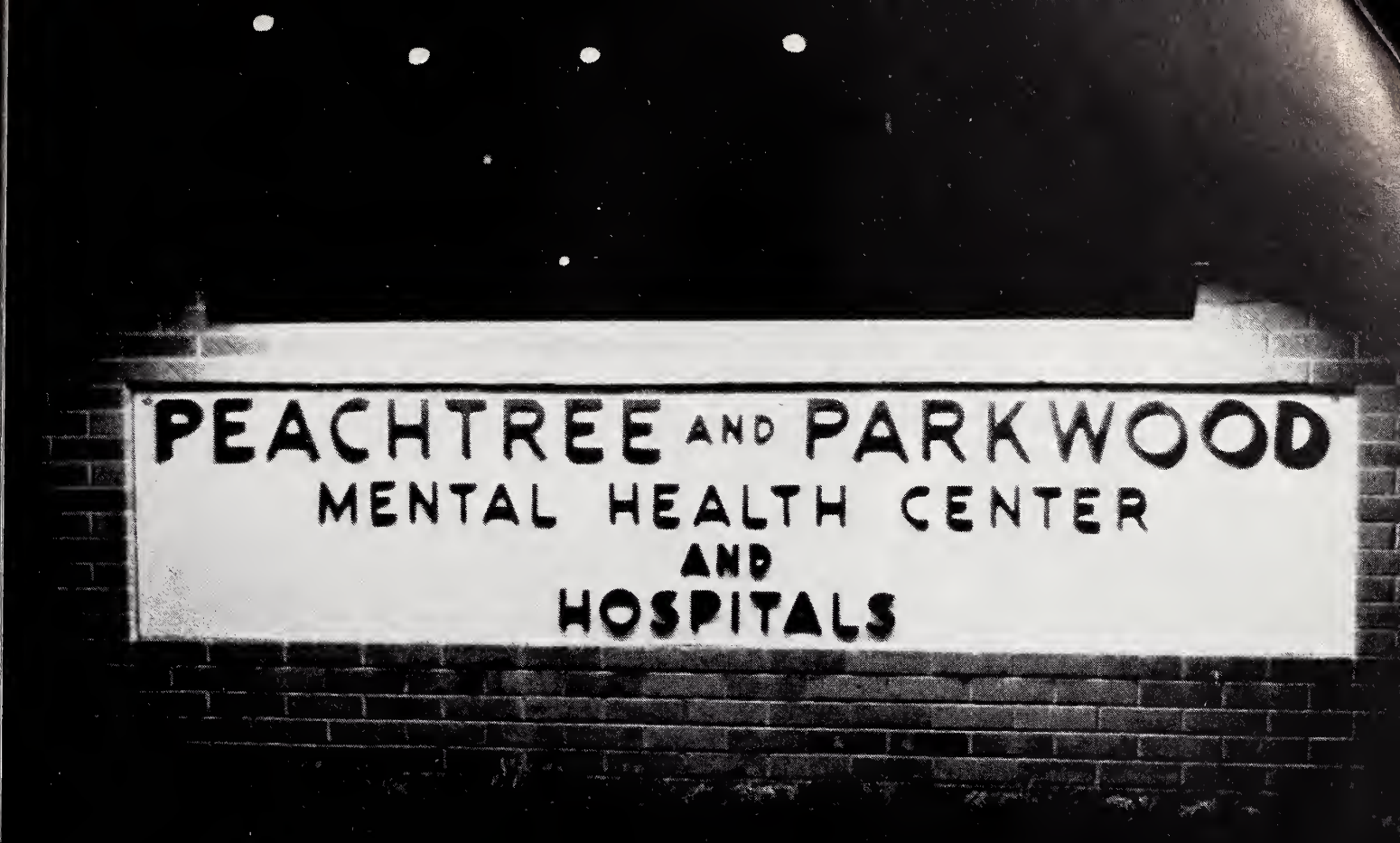








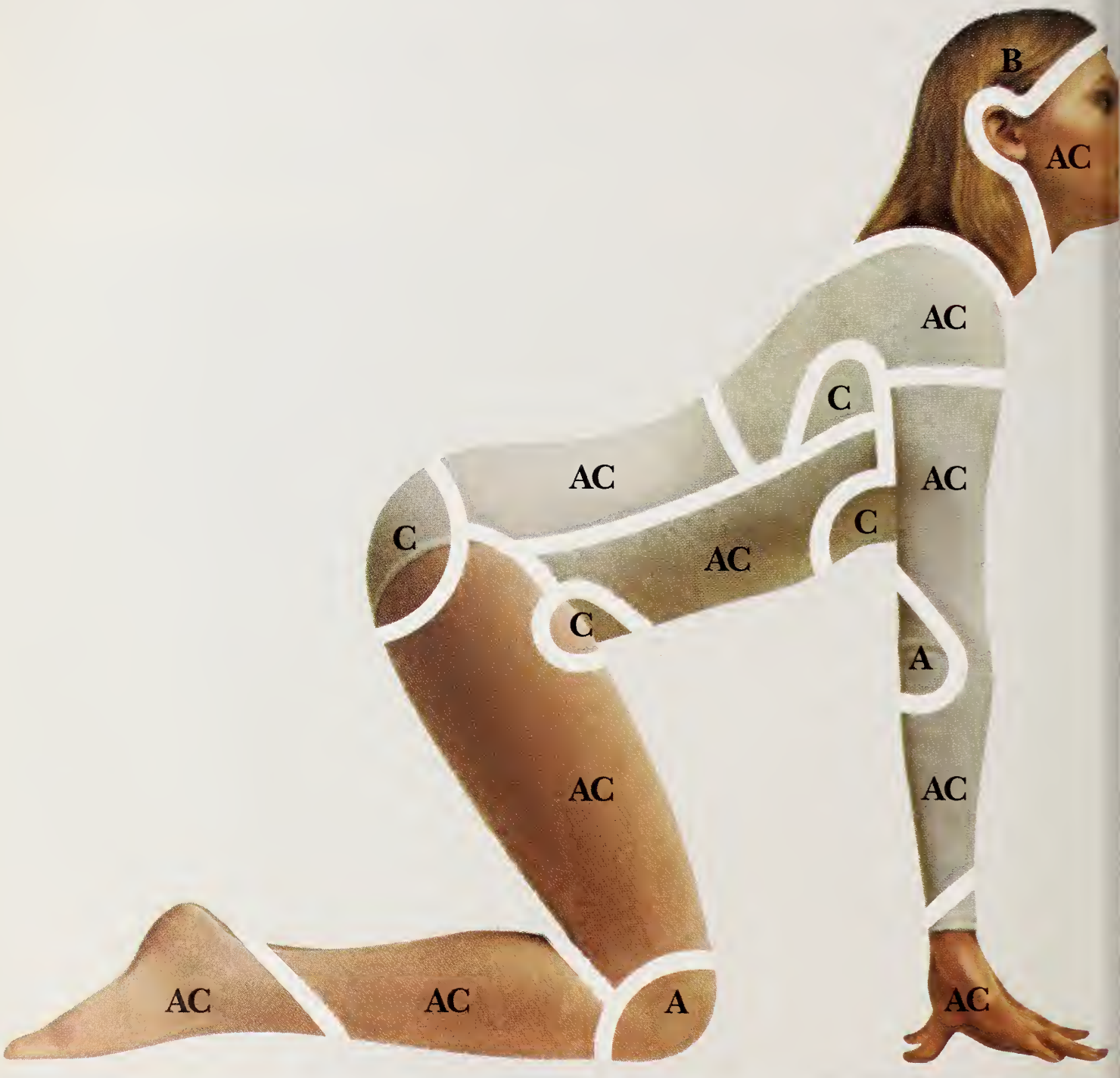
Speakers at the symposium are: top row, Eliot Wigginton (who is talking with Aunt Arie Carpenter) and Austin Deslauriers, Ph.D.; middle row, Judge Phyllis Kravitch and James Knight, M.D.; bottom row, Norman Cousins and Rev. Dr. Donald Shriver Jr.



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*Majority of patients evaluated after 2 weeks' therapy. Data on file at Squibb Institute for Medical Research.

See next page for brief summary.

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PRECAUTIONS: *General*—If local infection exists, suitable concomitant antimicrobial or antifungal therapy should be administered. If a favorable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. If irritation or sensitization develops, the preparation should be discontinued and appropriate therapy instituted. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use during pregnancy has not been absolutely established; therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, striae, skin atrophy, secondary infection, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. Contact sensitivity to a particular dressing material or adhesive may occur occasionally (see PRECAUTIONS).

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely establish therefore, do not use extensively on pregnant patients, in lo amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptib organisms (including fungi other than candida). Should superinf tion due to nonsusceptible organisms occur, administer suitab concomitant antimicrobial therapy; if favorable response is not prom discontinue the preparation until adequate control by other o infectives is effected. If extensive areas are treated or if the occlus technique is used, the possibility exists of increased systemic abso tion of the corticosteroid; suitable precautions should be taken. irritation develops, discontinue the product and institute appropri therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramici are rare. Hypersensitivity to nystatin is extremely uncommon. Hyp sensitivity to neomycin has been reported and articles in the curr medical literature indicate an increase in its prevalence.

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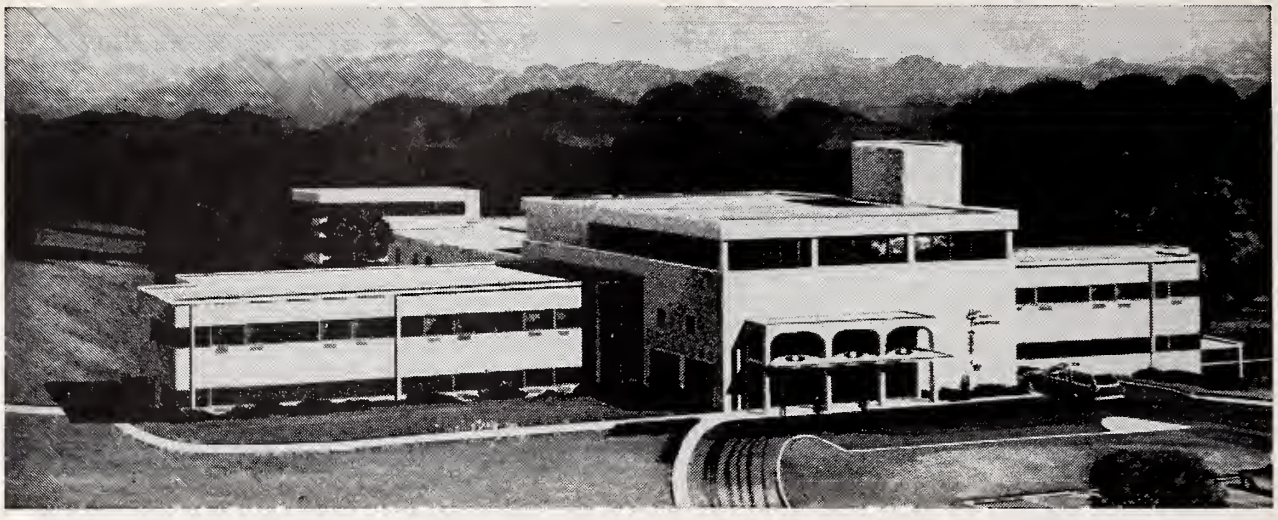
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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

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MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

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MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ROCHE

For recurrent attacks of urinary tract infection in women

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- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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- Low incidence of bacterial resistance in community practice
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- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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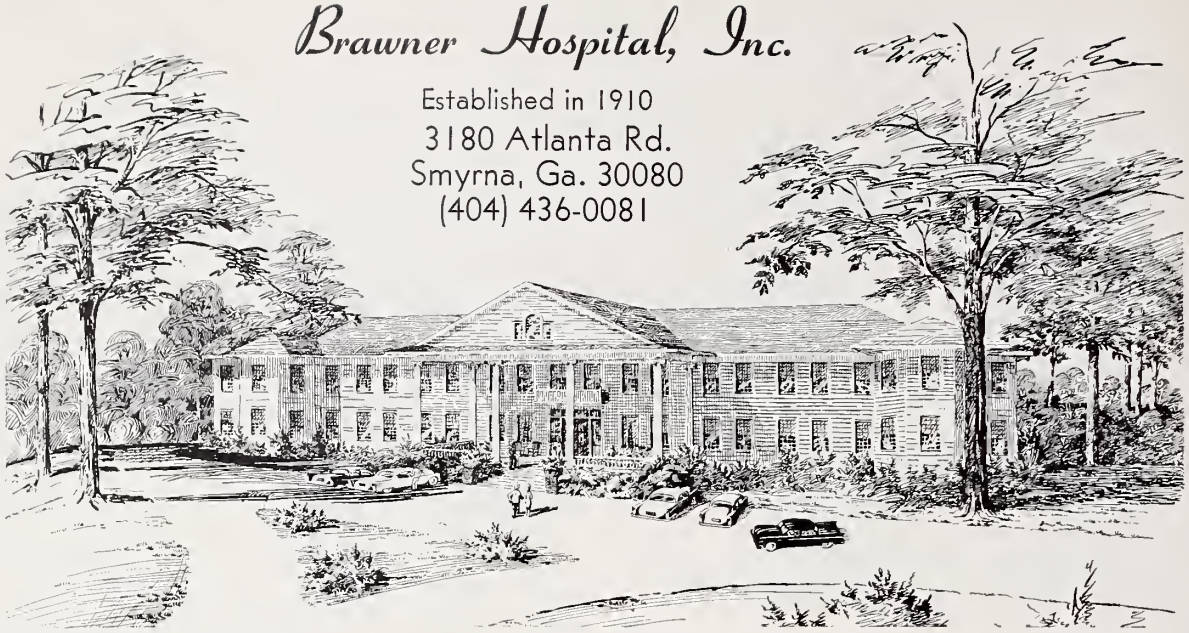
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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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COVER

Child abuse is a serious subject and one of special importance to doctors. The statistics are at best disturbing, as you will see from the article on page 195 and the editorial on page 226. This month's Legal Page, page 239, also deals with the subject. Cover design by Bob Hamill; photograph by Reg Hawkins.

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Letters to the Editor

Dear sir:

I have read with interest the editorial comment, "National Health Insurance Blasted" in the *JMAG,* December 1977 issue (page 949). It certainly is a refreshing change and contrasts greatly with articles recently found in the *New England Journal of Medicine* (298: p. 51, 1978).

I believe physicians might benefit by discussing the national health insurance concept with non-government economists. Many economic theorists have spoken about the subdued productivity and "entitlement approach" to life of people living under a benevolent dictatorial type of welfare government. An excellent example of this is the Soviet Union. A frequent complaint of Soviet migrants to the United States comes in form of soft demands for jobs, living quarters, etc.

These people cherish the freedom they experience in the United States, but are quite distraught when they learn the rewards they receive here are based on individual initiative and productivity rather than the collectivist approach, "what is good for the state."

This "open mouth" attitude is quite reminiscent of our own welfare, Veterans Administration and military systems.

I believe as physicians, we need to educate the public to the fact that *somebody* has to pay for any service rendered in a society. People are generally unable to grasp this concept. The general public may be under the misconception that they can maintain their present standards of living and still live in a welfare state. I do not believe many non-government economists would agree with this paradoxical situation.

In regard to the Soviet and British systems, the people have foregone a higher standard of living and accepted the benevolent welfare state.

As to the issue of national health insurance and individual liberty in this country, one economist, writing in the *Wall Street Journal,* put it quite vividly: "In this country there will always be room for private transactions between consenting adults."

Lewis H. Lipsus, M.D.
Marietta

Dear Sir:

I was very much interested in (the) careful evaluation of the number and distribution of primary care physicians in the state in the December 1977 issue of the *Journal* (written by Wells Riley, M.D. and H. Gordon Davis Jr., M.D., page 943).

However, as a practicing obstetrician/gynecologist, I must point out that (the authors) omitted a large group of physicians from your manpower study. As you well know, adult women are statistically the heaviest users of health care. Many of these women have no physician to provide care other than their gynecologist who provides them with periodic health maintenance examinations and carries out many of the same routine treatments for minor illnesses as the primary practitioner does for this group of patients. There are over 300 practicing OB-GYN specialists in the state, and my estimate would be that they spend a minimum of 50% of their time in health maintenance and other primary care activities.

Certainly these physicians should be used in calculating your physician/patient ratios. There are, as almost anyone would agree, low numbers of primary care physicians in Georgia. The effect of this is that all certified specialists simply perform many of the primary care duties for their patient population.

Another point relates to (the authors') basing (their) studies on need by county. (They) project that 80% of the counties will need primary care physicians by 1990. It is not clear how (they) made this determination. However, it must be realized that Georgia's county system is extremely inefficient and many experts in government organizations I'm sure would recommend that many of the counties in Georgia should simply be abolished and merged with other counties.

Although I'm sure my criticisms would not ultimately effect your carefully made conclusions, certainly they might effect the numbers which would appear to indicate a severe shortage of primary care physicians.

Joe B. Massey, M.D.
Atlanta

The Authors Reply

Dear Sir:

In response to Dr. Joe B. Massey's comment regarding omission of OB/GYN's from our study, the following information may be of interest to your readers.

It was the original intention of the Joint Advisory Board of Family Practice to include obstetricans and gynecologists in the survey. At the time the study was begun, the American College of Obstetrics and Gynecology had requested certification as a primary care specialty. During the time the study was being completed, they reversed their original decision and preferred not to be classified by the federal government as a primary care specialty. To our knowledge, this request still holds and they are not classified as a primary care specialty. This is supported by release of federal funding for development of primary care specialty in internal medicine and pediatrics, as well as family medicine: obstetrics and gynecology was not included in this grant.

We hope this adequately explains the position taken in the study.

H. Gordon Davis, M.D. (Chairman)
Wells Riley, M.D.
Joint Advisory Board of Family Practice
Atlanta

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Medical Meeting Calendar

APRIL

1-4—*Atlanta;* **MEETING FOR FOOTBALL TEAM PHYSICIANS;** Contact: Sports Medical Foundation of America, 615 Peachtree St., N.E., Atlanta 30308.

4—*Atlanta;* **ASSESSMENT AND MANAGEMENT OF THE SUICIDAL PATIENT;** Contact: Humanics Associates, Suite 114, 881 Peachtree St., Atlanta 30309.

4—*Fort Oglethorpe;* **GASTROENTEROLOGY;** Category 1 Credit; Contact: Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe 30741.

5-7—*Atlanta;* **TECHNIQUES IN ORTHOPAEDIC SURGERY;** Category 1 Credit; Contact: Georgia E. Dreger, Ed.D., 107 Medical Administration Building, Emory University, Atlanta 30322. PH: 404/329-5535.

6-7—*Marietta;* **THE HUMAN RESPONSE TO CHANGE: COBB COUNTY MEDICAL SOCIETY ANNUAL SYMPOSIUM;** Contact: Kennesaw College, Marietta 30061. PH: 404/422-8770.

6-7—*Callaway Gardens;* **SIXTH ANNUAL CONFERENCE ON PERINATAL MEDICINE;** Category 1 Credit; Contact: Micki L. Souma, M.D., Louis I. Levy, M.D., Perinatology, The Medical Center, P.O. Box 951, Columbus 31902.

6-9—*Atlanta;* **1978 SPRING INSTITUTE AHME** (Association for Hospital Medical Education); Contact: Ms. G. M. Coleman, 1911 Jefferson Davis Highway, Suite 905, Arlington, VA 22202.

7-8—*Callaway Gardens;* **EIGHTH CANCER SEMINAR;** Category 1 Credit; Contact: American Cancer Society, Georgia Division, 2025 Peachtree Rd., NE, Atlanta 30309.

10-12—*Atlanta;* **FIRST INTERNATIONAL HISTOPLASMOSIS CONFERENCE;** Category 1 Credit; Contact: American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

10-15—*Atlanta;* **DIAGNOSIS AND TREATMENT IN LOCOMOTOR DISORDERS, II;** Category 1 Credit; Contact: J. Robin deAndrade, M.D., Emory University School of Medicine, Atlanta 30322.

11-12—*Augusta;* **NEONATOLOGY;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

12-22—*Savannah;* **GEORGIA RADIOLOGICAL SOCIETY SPRING MEETING;** Category 1 Credit; Contact: Theodora Vanderzalm, M.D., Georgia Radiological Society, Medical College of Georgia, Augusta 30901.

13-14—*Atlanta;* **ANNUAL MEETING, AMERICAN GERIATRICS SOCIETY;** Category 1 Credit; Contact: Kathryn S. Henderson, Executive Director, American Geriatrics Society, 10 Columbus Cr., Room 1470, New York, NY 10019. PH: 212/582-1333.

13-15—*Augusta;* **OBSTETRICS AND GYNECOLOGY;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

13-15—*Atlanta;* **HIP AND SPINE IN PEDIATRIC ORTHOPAEDICS;** Category 1 Credit; Contact: E. William Schmitt, Jr., M.D., Emory University School of Medicine, Atlanta 30322.

14-15—*Atlanta;* **CORONARY ARTERY DISEASE: CURRENT TRENDS AND CONCEPTS;** Contact: Arnoldo Fiedotin, M.D., St. Joseph's Hospital, 5665 Peachtree-Dunwoody Rd., Atlanta 30340.

14-15—*Chattanooga, TN;* **FOURTH ANNUAL PEDIATRICS SYMPOSIUM;** Contact: University of Tennessee, College of Medicine, Clinical Education Center, Suite 400, 921 East Third St., Chattanooga, TN 37403.

14-15—*Kiawah Island, SC:* **SPECIAL PROCEDURES WORKSHOP;** Category 1 Credit; Contact: Southeastern Angiographic Society, 5223 Paulsen St., Savannah 31405.

18, 25—*Atlanta;* **GROUP AND FAMILY THERAPY;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., N.E., Atlanta 30326.

24-25—*Atlanta;* **CLINICAL ASPECTS OF FAMILY PLANNING FOR PHYSICIANS;** Category 1 Credit; Contact: Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303.

25-28—*Atlanta;* **CLINICAL BIOFEEDBACK TRAINING, IV;** Category 1 Credit; Contact: Department of Rehabilitation Medicine, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-4874.

27-29—*Atlanta;* **THREE DAYS OF HEPATO-BILIARY DISEASES;** Category 1 Credit; Contact: John T. Galambos, M.D., Emory University School of Medicine, Atlanta 30322.

27-29—*Atlanta;* **POSTGRADUATE COURSE ON GYNECOLOGICAL ONCOLOGY;** Category 1 Credit; Contact: American Cancer Society, Georgia Division, 2025 Peachtree Rd., N.E., Atlanta 30309.

27-30—*Sea Island;* **PRACTICAL OPHTHALMIC PLASTIC SURGERY;** Category 1 Credit; Contact: Georgia Society of Ophthalmology, 542 Church St., Decatur 30030.

30-May 3—*Savannah;* **ANNUAL MEETING, GEORGIA PUBLIC HEALTH ASSOCIATION;** Contact: Jack M. Landrum, Georgia Department of Human Resources, 618 Ponce de Leon Ave., Atlanta 30308.

MAY

3-8—*Atlanta;* **ANNUAL MEETING, AMERICAN PSYCHOANALYTIC ASSOCIATION;** Category 1 Credit; Contact: Helen Fischer, Administrative Director, American Psychoanalytic Association, 1 East 57th St., New York, NY 10022. PH: 212/752-0450.

4-7—*Atlanta;* **FRONTIERS OF ADOLESCENT PSYCHIATRY;** Category 1 Credit; Contact: Joe W. King, M.D., President, American Society for Adolescent Psychiatry, 24 Valley Rd.. Wallingford, PA 19086. PH: 215/566-1054.

8-10—*Atlanta;* **CARDIOVASCULAR PHYSIOLOGY FOR PRACTICING PHYSICIANS;** Category 1 Credit; Contact: J. Willis Hurst. M.D., Emory University School of Medicine, Atlanta 30322.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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INDICATION: Contraception [ ]

CONTRAINDICATIONS: Oral contraceptives (OC's) should not be used in women with any of the following conditions:

1. Thrombophlebitis, thromboembolic disorders or conditions which predispose to these disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS:

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely to develop these diseases without evident cause than are nonusers. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4 to 9.5 times greater in users than in nonusers. [ ]

An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported, confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. [ ]

In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Cases of thromboembolic disease have been reported in women using progestin-only oral contraceptives, and they should not be presumed to be free of excess risk.

The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. [ ]

The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. [ ] The study concluded that the mortality associated with all methods of birth control is low compared to the risk of childbirth, with the exception of oral contraceptives in women over 40, and that the lowest mortality is associated with the condom or diaphragm backed up by early abortion.

The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

A four- to six-fold increased risk of post-surgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery. [ ]

2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; sudden onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures.

3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. [ ]

In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. [ ]

One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented.

In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

4. HEPATIC ADENOMA. Benign hepatic adenomas appear to be associated with the use of oral contraceptives. Although benign, and rare, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives, although one study relates risk with duration of use of the contraceptive. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. [ ]

5. USE IN PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes.

Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb-reduction defects. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births.

In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestins are effective for these uses.

There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown.

Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend 3 months.

The administration of progestin-only or progestin-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. GALLBLADDER DISEASE. Studies report a doubling of the risk of surgically confirmed gallbladder disease in users of oral contraceptives or estrogen for 2 or more years.

7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives.

8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives.

9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause.

10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. [ ] Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease.

Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods.

11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. However, in oral contraceptive failures, the ratio of ectopic to intrauterine pregnancies is higher than in women who are not receiving oral contraceptives, since the drugs are more effective in preventing intrauterine than ectopic pregnancies. [ ]

12. BREAST FEEDING. Oral contraceptives given in the postpartum period interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. [ ] If feasible, the use of oral contraceptives should be deferred until the infant has been weaned.

PRECAUTIONS: General 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than 1 year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered.

d. Decreased pregnanediol excretion.

e. Reduced response to metyrapone test.

INFORMATION FOR THE PATIENT (See Patient Package Insert)

DRUG INTERACTIONS: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. [ ]

ADVERSE REACTIONS: An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS):

Thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

Mesenteric thrombosis; benign hepatomas; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related:

Nausea, usually the most common adverse experience; vomiting reaction, occurring in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally; gastrointestinal symptoms (such as abdominal cramps and bloating); breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma which may persist; breast changes: tenderness, enlargement and secretion; change in weight (increase or decrease); change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis.

The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted:

Premenstrual-like syndrome; intolerance to contact lenses; change in corneal curvature (steepening); cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache, nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria; impaired renal function.

ACUTE OVERDOSE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females. [ ]

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Child Abuse in Georgia: A Duty to Report

BARBARA S. CUNDIFF, A.C.S.W., *Atlanta**

PHYSICAL AND SEXUAL ABUSE of children is perhaps the most difficult form of social illness we have to face as professional persons—whether we are physicians, social workers or law enforcement officials. It has long remained a family secret protected by parents, relatives and other community persons afraid to get involved to intervene in a parent-child relationship—regardless of how damaging to the child.

It was only in the 1960's that laws came about to require certain professionals to report child abuse and neglect and provide for immunity from civil and criminal liability to persons reporting in good faith. Georgia Code 74-111 has undergone amendments periodically to provide as comprehensive a protection for children as possible. (See Legal Page, p. 239 of this issue.)

To further enforce reporting, the Georgia General Assembly in 1977 provided that any person or official required to report "who knowingly and willfully fails to do so shall be guilty of a misdemeanor and upon conviction thereof shall be punished as for a misdemeanor."[1]

The county Departments of Family and Children Services, since the U.S. Social Security Act of 1935, have provided child protective services. The programs and services have expanded considerably over the years as laws have been strengthened to protect children from harm. The Child Abuse Central Registry, however, was not established until 1971. The Registry is located within the Division of Family and Children Services of the Georgia Department of Human Resources. Upon receiving a report of physical and/or sexual abuse, the local protective services worker is to investigate the report and submit information to the Central Registry. The primary purpose of the Registry is to be a clearinghouse for county departments to determine if a prior report has been received on a child; this may take place by an inquiry from the county department or by a routine check of all new reports with existing reports. Appropriate local staff are always notified when two reports have been received on the same child or siblings. The Registry also provides data as to the incidence of abuse, types of injuries and other pertinent data. The reporting trend in the past five years is quite remarkable (see chart).

Of all the child abuse cases reported in 1977, only 3% were reported by physicians

With the strengthening of the reporting law and the Department's increased efforts at educating the community on the problem, there has been a significant increase in reporting by almost all mandated reporters.

It is of concern that in 1973 private physicians reported 7% of the children, but in 1977 *only 3%*. While many private physicians may be referring children for hospital care, it is doubtful that this could totally account for the low numbers reported. Perhaps the private physician, of those required to report, does not represent a larger institution with support staff available to double-check suspicion or to have persons to call his attention to the less obvious indicators of child abuse. Perhaps he thinks the parenting problem will solve itself without his reporting to authorities or that his own periodic

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REPORTING OF PHYSICAL AND SEXUAL ABUSE IN GEORGIA
A FIVE-YEAR SPAN

	1973	1977	% Increase
Children reported	346	1,451	319
Referrals from:			
Private physicians	24(7%)	45(3%)	88
Relatives	51(14%)	184(12%)	260
Hospitals/clinics	53(18%)	214(15%)	303
Police	34(10%)	144(10%)	324
Concerned citizens	51(14%)	235(16%)	361
School officials	46(13%)	242(17%)	426
Parents	18(5%)	109(8%)	506
Others	69(19%)	278(19%)	302
	277	1,173	

counseling and advice will help the parents solve the problem.

The one thing we have learned in the past ten years is that child abuse gets worse without medical, social or sometimes legal intervention. *Nineteen children died* in Georgia last year from suspected physical and sexual abuse; only one child had a known history of physical abuse and two children had a history of suspected abuse.

Due to extensive medical training, it is critical that physicians be involved in the identification and treatment of physical and sexual abuse of children. Frequently, it requires a medical determination that the injuries to the child and the parents' explanation do not fit; others involved in the field of child abuse and neglect, such as social workers, law enforcement personnel and judges, do not have the physician's expertise.

A thorough diagnostic determination of physical abuse, particularly for children five years and under, requires temporary hospitalization and examination for hidden injuries and past trauma. Medical specialists in child abuse routinely conduct long bone, skull and chest X-ray examinations to determine if there have been prior bone fractures. Most parents will cooperate with the physician's request to hold the child overnight for further examination. If the family is resistant, the physician or hospital staff may contact the protective services staff in the county department who can assist in obtaining a protective hold order from the juvenile judge. The physician also has the option of calling the judge directly.[2-3]

The physician should inform the parents that he is required by state law to report injuries that appear non-accidental to protective services. This can and should be done in as non-threatening a manner as possible with assurance that all involved will attempt to help the family with the problems that caused the child's injuries. It is preferable that protective services become involved with the family immediately, prior to the child's release from the hospital, in order to conduct a social evaluation of the family and determine if it is safe for the child to return home.

The primary purpose of protective services is to protect the child in his own home when possible. Supportive services may include casework services, homemaker services, protective day care, individual therapy for child and parents, referrals to other community services, etc. If rehabilitative efforts are not successful and home conditions pose hazardous consequences for the child, the protective services staff may petition the juvenile court to obtain substitute care for the child. Of the 1,451 children reported in 1977, abuse was ruled out for 345, court action was initiated for 226 children (20%), and 877 children (80%) remained in their home under protective supervision.

"Nineteen children died in Georgia last year from suspected physical and sexual abuse; only one had a known history of abuse and two had a history of suspected abuse"

For information regarding local reporting procedures, contact your county Department of Family and Children Services.

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Two cases are reported along with a discussion of pertinent aspects of the pathogenesis and treatment of each. In one case, the organism Edwardsiella, an unusual genus of Enterobacteriaceae, is reported for the first time in the literature as a causative agent.

Infected Arterial Aneurysms

H. TURNER EDMONDSON, M.D., WILLIAM L. MOORE JR., M.D., J. PETER RISSING, M.D., and WILLIAM L. DIXON, M.D., *Augusta

THE FIRST RECORDED DESCRIPTION of an infected arterial aneurysm is attributed to Koch in 1851. The term "mycotic" was first used by Osler in 1885 to define aneurysms resulting from bacterial endocarditis with septic embolization. Probably because of Osler's preeminence, the term "mycotic" has persisted to describe all infected aneurysms, even though "mycotic infections" are generally considered to be caused by fungi. A recent report of mycotic aneurysms has also included false aneurysms. These are really infected hematomas that occur after arterial injury or suture line disruption.[1]

In this paper, we are reporting two cases of infected true aneurysms, along with a discussion of pertinent aspects of the pathogenesis and treatment of each. In one of our cases, the organism was Edwardsiella, an unusual genus in the family *Enterobacteriaceae*. This bacteria has not previously been reported as a causative agent in infected aneurysms.

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Case Reports

Case I: A 55-year-old black male was admitted on September 10, 1975, to his community hospital because of a rapid onset of confusion, shock (BP 86/80, P 120), temperature elevation to 105°, and dehydration. Five days prior to admission, he punctured his finger while handling a catfish. Blood culture yielded an unidentified gram negative rod, and Cephalothin and Gentamicin antibiotics were begun.

After three days in the community hospital, he improved somewhat and was transferred to the Medical Service of the VA Hospital in Augusta, Ga. He was well known to this hospital because, in February 1975, he had had an aortic valve prosthesis implanted for severe aortic insufficiency. He had been followed in the clinic and had done very well since his cardiac surgery.

Evaluation of the patient at the VA Hospital revealed a five cm round, pulsating, firm mass located in the left mid-abdomen. The patient was oriented, although lethargic, and could not remember having

felt the mass before. It was not felt by the examining physician at the hospital from which he was transferred. Repeat blood culture at the VA Hospital yielded a gram negative aerobic rod, *Edwardsiella,* sensitive to Gentamicin. He was kept on this antibiotic for three days, but the blood cultures remained positive for this organism and the abdominal mass became larger. He had no clinical evidence of prosthetic endocarditis when admitted. There were no pathologic murmurs, and angiographic examination of the heart showed a normally functioning prosthesis.

Aortogram confirmed the aneurysm (Fig. 1). It was further concluded that, although the prosthetic valve may be contributing to the blood stream infection, the aneurysm was also probably infected and immediate surgical treatment was indicated.

The abdomen was opened on September 29 and a nine cm saccular aneurysm was found, which extended from just below the renal arteries to the aortic bifurcation. The overlying peritoneum was very inflamed and numerous large inflamed lymph nodes lay within the retroperitoneal tissues and adjacent to the aneurysm. The wall of the aneurysm at its greatest convexity was thin, suggesting that rupture was imminent. It was decided that the aneurysm should be excised; this was time-consuming because of its purulent and friable consistency. The pathologist reported that the excised tissue appeared infected and contained many inflammatory cells, but the organism could not be cultivated. However, gram negative rods were seen on stain.

The post-operative course was stormy. He drifted into renal failure. Small brain abscesses were suspected because of mental deterioration and convulsive activity. Chloramphenicol was started and Gentamicin discontinued because of renal failure.

The patient's general condition gradually deteriorated with progression of renal failure and gastrointestinal bleeding. Blood cultures were negative for ten days after aneurysm resection, but on the twelfth post-operative day, he spiked a temperature to 104°and blood cultures grew out Serratia. He expired on October 20, the 21st post-operative day.

Autopsy findings included: (1) Bacterial endocarditis *(Serratia marcescens)* of aortic outflow tract and mitral valve; (2) multiple organ septic infarcts (spleen, liver, brain); (3) patent aortic graft prosthesis without evidence of infection, and (4) gastric ulcer.

Case II: N.W., a 56-year-old white woman, had a basal cell epithelioma surgically removed from her scalp in September 1969. One month later, she developed moderately severe pain in her lower back, radiating to the right sacroiliac joint and daily temperature elevations of 39°C. Some superficial crust-



Fig. 1—Arteriogram showing presence of abdominal aortic aneurysm (above).



Fig. 2—Lateral x-ray of abdomen showing calcified but normal sized abdominal aorta (right).

ing sores were noted about the healed scalp incision.

A thorough medical evaluation, including studies of the gastrointestinal tract, gallbladder, and kidneys, revealed no source of the pain and fever. A lateral X-ray of the abdomen revealed calcification in the abdominal aorta, but no suggestion of aneurysm (Fig. 2). Blood cultures were sterile. The symptoms responded to indomethicin therapy; hence a diagnosis of arthritis was entertained and the patient discharged.

About two weeks later, the patient was awakened by severe right flank and back pain. A tender pulsatile mass was palpated in the upper abdomen, extending three centimeters below the umbilicus. The temperature was elevated to 101°. An abdominal X-ray showed a change in the previously noted calcifications in the abdominal aorta (Fig. 3). A diagnosis of aneurysm of the abdominal aorta was made. At operation, an atherosclerotic aneurysm six cm in diameter, extending from two cm below the renal arteries to the aortic bifurcation, was found. The retroperitoneal tissues were inflamed and adherent to the aorta. No obviously purulent material was seen. A teflon tube graft was placed without difficulty.

Cultures of tissue and thrombus taken at surgery grew out staphylococcus aureus, coagulase positive of the same phage type as those taken from the crusting lesions on the scalp. The patient received 24 million units of aqueous penicillin IV daily for four weeks and then 3.2 million units orally for four weeks. The post-operative course was uncomplicated. When seen recently—six years after her operation—she was well.

Comment

Pathogenesis: The pathogenesis of infected (or "mycotic") aneurysms has been described in numerous reports.[1–4, 6–8, 10, 11] Several mechanisms are usually enumerated and are summarized as follows:

First, septic emboli, usually from bacterial endocarditis, may lodge within a narrowed segment of artery and set up a focus of infection. The intima is destroyed which allows the spread of infection into the media. Localized weakening results in aneurysm formation. The aortic arch may be more directly affected in bacterial endocarditis by septic spread of the infection via the right coronary and into the vasa vasorum.

Second, an atherosclerotic aneurysm may become secondarily infected by hematogenous seeding from bacteremia of known or unknown cause. In this category, the aneurysm may not be diffusely involved, and the site of potential rupture often coincides with the actual area of "pointing" at the most concentrated area of infection. This has been described to differentiate secondarily infected aneurysms from those aneurysms that developed primarily from arterial wall weakening due to bacterial invasion.

A third mechanism involves direct extension from an adjacent focus of infection. This may involve the lymphatic route and has been mentioned as being common with Tuberculous aneurysms.

Vio, et al. described the vasa vasorum of the abdominal aorta as arising from the lumbar arteries. This may be a route of infection when osteomyelitis of the lumbar vertebra exists.[13]

A fourth mechanism describes the lodgement of bacteria at sites of atherosclerotic internal disruption, which in turn results in a localized arteritis with weakening of the arterial wall and eventual aneurysm formation. It seems reasonable for bacteria of hematogenous origin to become harbored within crevasses which result from the destructive forces of atherosclerosis. There may be a localized reduction of arterial wall defenses as the intima of large arteries normally derives its nutrition by diffusion of plasma from the main intraluminal blood stream. Atherosclerotic thickening and hardening of the intima may interfere with de-



Fig. 3—Lateral x-ray of abdomen showing change in size of abdominal aorta as evidenced by anterior expansion and disruption of calcified aortic wall.

livery of phagocytes and antibodies to combat the invading bacteria.

A fifth mechanism concerns the formation of infected false aneurysms. It has been suggested that these should be included with a discussion of true aneurysms since the problems of management are similar. Injury and contamination, as in narcotic addicts who "mainline" with unsterile needles, may produce an infected hematoma. Also, an infected hematoma may result from an infected vascular graft with suture line disruption. The hematoma undergoes liquefaction of its central portion and a false aneurysm develops.

We feel that hematogenous seeding into atherosclerotic diseased sites was probably responsible for the aneurysm formation in both of our cases, as there was no evidence of pre-existing aneurysm. In the second case, there was radiographic evidence that the abdominal aorta was diseased and calcified prior to aneurysm formation.

Location: Infected true aneurysm from all causes have been reported in diverse anatomical sites. Virtually any systemic artery may be involved. Occurrences are more common at sites of atheromatous disease and points of branching. Infected aneurysms that arise as a consequence of "mainlining" by addicts are frequently located in the common femoral, brachial, and common carotid arteries.[1, 3, 7]

In bacterial endocarditis, about 90% of mycotic aortic aneurysms involve the ascending aorta and arch. The rarity of pulmonary valve endocarditis is a partial explanation for the rarity of pulmonary artery mycotic aneurysms.[2]

Bacteriology: The advent of antibiotic era and changing patterns of bacterial resistance has brought about variations in occurrence of responsible organisms. Prior to 1945, most infected aneurysms were secondary to SBE, with Streptococcus viridans, *Streptococcus pneumoniae,* or *Hemophilus influenzae* isolated most frequently. In 1967, Bennett and Cherry[4] reviewed the world literature and concluded that Staphylococcus and Salmonella were emerging in the etiology of both primarily infected aneurysms and those secondarily infected from Salmonella endocarditis. Anderson[1] reported sixteen cases in 1970 and found staphylococcus and Enterobacter the most common organisms isolated. The anaerobes, Bacteriodes and Peptostreptococcus, as well as Candida, were also isolated. Salmonella was not recovered in any of their cases. Jarett, et al.,[6] reported 17 consecutive patients with infected abdominal aortic aneurysms and found staphylococci (41%) and Salmonella (18%) most commonly. Also isolated were *E. Coli,* Pseudomonas, Proteus, Klebsiella, Streptococci, Pneumonococci, gram-positive bacilli, and Mycobacterium Tuberculosis. In our first case, Edwardsiella and Serratia were both implicated. Due to the sequence of events, it appears that Edwardsiella was the initial organism to infect the diseased aorta (from arteriosclerosis) and create the aneurysm. This is the first report of this organism being implicated in the etiology of an infected aneurysm.

Diagnosis: The symptoms and findings exhibited by our two cases are in accordance with those reported previously. Fever in association with a rapidly expanding aneurysm should be considered diagnostic unless the temperature elevation has an obvious origin elsewhere. Failure to demonstrate X-ray evidence of calcium suggests rapid expansion. A positive blood culture, particularly when associated with a suspected source of infected emboli such as bacterial endocarditis, also suggests an infected aneurysm.

When exposed at the operating table, an infected aneurysm may be surrounded by inflamed soft tissues and enlarged nodes. Existing aneurysms that have become secondarily infected may have a localized area of inflammation (in other words, "pointing"). A secondarily infected aneurysm can usually be differentiated by this localization of the secondary infection. Bennett and Cherry[2] suggest that infections probably develop in aortic aneurysms more frequently than is indicated by the relatively few cases in the literature. Since the infected aortic aneurysm may, on occasion, differ very little in gross appearance from the ordinary ruptured arteriosclerotic aneurysm, it may be wise to routinely gram stain and culture the aneurysmal contents in all cases—for both aerobes and anaerobes.

Treatment: Three principle approaches are to be considered:

First, small arteries may be simply ligated, the aneurysm completely excised, and the area drained. Of course, the ability of the extremity or other area to survive must be taken into consideration. Later revascularization may be indicated after the infection has subsided. Distal, as well as proximal ligation, has been emphasized when possible because, without distal ligation, secondary hemorrhage will frequently occur.[7]

Second, bypass procedures through uninfected tissue planes have been successfully employed. The risks of bypass must be weighed against the risk of potential complications, should the bypass become infected at the anastomoses. Bypass techniques have been well described in recent reviews.[8, 9, 12]

Third, the aneurysm may be excised and a replacement graft inserted at the time. If this ap-

proach is taken, it is imperative that all of the aneurysmal wall, degenerated clot, and inflammatory debris should be completely excised. In our two cases, a synthetic aortic bifurcation graft was successfully used and supported by intense antibiotic therapy. In our first case, the patient unfortunately expired as a consequence of renal failure, but the graft site exhibited no gross or bacteriological evidence of persistent infection after 21 days. Antibiotics were continued for three months in our second case. Goldstone and Moore[5] demonstrated in their laboratory that Dacron aortic grafts can be infected via the blood stream up to four months after implantation. Prior soaking of the graft with antibiotic solution is probably of value.

The choice of antibiotics depends upon bacteriologic identification of the organisms if possible. If the organism cannot be identified, perhaps its identity can be reasonably suspected. For example, a foul smelling exudate suggests anaerobic involvement; then clindamycin or choloramphenicol should be given. A good starting choice to cover both gram positive organisms such as staphylococci and gram negative aerobes would be a cephalosporin combined with an aminoglycoside.

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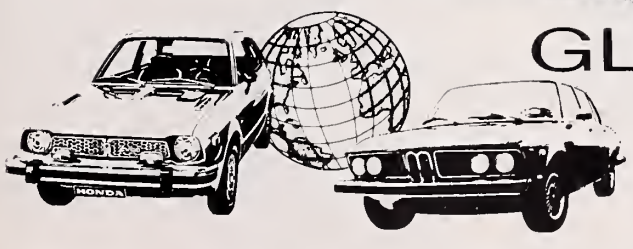
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Clinical Infections and Antibiotics

The following table was printed on page 24 of the January 1978 Journal *("Clinical Infections and Antibiotics" by William E. Mitchell, M.D., page 22), but was not organized correctly. The table is reprinted here in proper format.*

TABLE 2

SITE AND GRAM KNOWN—NEITHER IDENTIFICATION NOR SENSITIVITY KNOWN

A. Wound Organisms

Gram (–) Rods

E. coli	50
Proteus	32
Bacteroides	23
Klebsiella	15
Enterobacter	14
Pseudomonas	10
Others	10

Gram (+) Cocci

Staph. epi	53
Staph. aureus	43
Enterococcus	25
Alpha Strep. (not D)	7
Beta Strep. (not A, B or D)	6
Others	18

Likelihood of Sensitivity to Each Antibiotic†

Gram (–) Rods	% Sensitive
Gentamicin	97
Tobramycin	97
Septra/Bactrim	84
Kanamycin	82
Chloramphenicol	80
Colimycin	78
Nalidixic Acid	71/88*
Sulfisozole	69
Cephalosporin grp.	68
Carbenicillin	68
Nitrofurantoin	62
Ampicillin	46

Gram (+) Cocci	% Sensitive
Chloramphenicol	96
Cephalosporin grp.	92
Clindamicin grp.	89
Erythromycin	86
Gentamicin	84
(Tobramycin	84)
Semisynthetic penicillin grp.	74
Kanamycin	70
Tetracycline grp.	61/72*
Ampicillin	41
Penicillin	24

B. Urinary Tract Organisms

Gram (–) Rods

E. coli	168
Proteus	58
Pseudomonas	46
Klebsiella	37
Enterobacter	22
Serratia	10
Citrobacter	4
Others	2

Gram (+) Cocci

Enterococcus	77
Staph. epi.	28
Alpha Strep. (not D)	16
Alpha Strep. (D)	8
Staph. aureus	8
Others	10

Gram (–) Rods	% Sensitive
Gentamicin	97
Tobramycin	96
Colimycin	69/91*
Kanamycin	83
Chloramphenicol	80
Tetracycline grp.	68
Cephalosporin grp.	63
Carbenicillin	53
Ampicillin	44
Erythromycin	18

Gram (+) Cocci	% Sensitive
Chloramphenicol	94
Clindamycin grp.	90
Erythromycin	85/96*
Gentamicin	79
Tobramycin	79
Cephalosporin grp	76/65*
Kanamycin	49
Tetracycline grp.	35/45*
Ampicillin	36
Semisynthetic penicillin grp.	33
Penicillin	18

† Assumes Beta strep and Strep Pneumoniae sensitive to usual gram (+) effective antibiotics, and Haemophilus uniformly sensitive.

* Community %/Hospital %.

NT—Not tested.

C. Respiratory Tract Organisms

Gram (–) Rods

Hemophilus	95
E. coli	78
Klebsiella	60
Pseudomonas	55
Enterobacter	49
Proteus	29
Serratia	24
Acinetobacter	12

Gram (+) Cocci

Staph. aureus	43
Beta Strep. (not A, B, D)	13
Strep. Pneumoniae	10
Staph. epi.	7

Likelihood of Sensitivity to Each Antibiotic†

Gram (–) Rods	% Sensitive
Chloramphenicol	82
Tobramycin	83/73*
Gentamicin	79
Kanamycin	76/56*
Carbenicillin	65
Colimycin	64
Cephalosporin grp.	60/46*
Tetracycline grp.	51/38*
Ampicillin	39

Gram (+) Cocci	% Sensitive
Chloramphenicol	99
Erythromycin	96
Clindamycin grp.	94
Cephalosporin grp.	92/69*
Semisynthetic penicillin grp.	92/67*
Gentamicin	71
Kanamycin	68
(Tobramycin	68)
Tetracycline grp.	55
Ampicillin	42
Penicillin	27/55*



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Use of Echocardiography in the Diagnosis of Prolapsed Tricuspid Valve

ELIAS KARAYANNIS, M.D., MILTIADIS A. STEFADOUROS, M.D.,
ABDULLA M. ABDULLA, M.D., and JAMES C. BLACKWELL, M.D., *Augusta**

In this report, two cases of isolated tricuspid valve prolapse detected by echocardiography are presented. These cases emphasize the importance of echocardiography in identifying prolapsed tricuspid valve as the site of production of late systolic murmur or as the possible cause of otherwise unexplained attacks of paroxysmal atrial tachycardia

In contrast to the high incidence of prolapsed mitral valve syndrome,[1–5] the reported number of patients with tricuspid valve prolapse is surprisingly small. Thus, out of 21 cases of tricuspid valve prolapse, documented by angiocardiography,[6, 7] echocardiography,[8] or both,[9] reported in four separate studies, mitral valve prolapse co-existed in 15, and of the remaining six patients with isolated tricuspid involvement, the prolapse was echocardiographically demonstrated in only five.[8, 9] In this report, two additional cases of isolated tricuspid valve prolapse detected by echocardiography are presented.

Case Report No. 1

A 43-year-old black woman was admitted to the Eugene Talmadge Memorial Hospital on July 14, 1976, because of exercise intolerance, orthopnea, paroxysmal nocturnal dyspnea, and pedal edema, progressively increasing over the past three months. These symptoms first appeared in January 1976 when she was admitted to this hospital where a diagnosis of pulmonary hypertension secondary to multiple bilateral pulmonary emboli from unidentified source was made on the basis of physical examination, phonocardiogram, electrocardiogram, chest X-ray and perfusion lung scan; anticoagulation treatment was administered and, after considerable improvement, the patient was discharged on digoxin 0.25/mg, hydrochlorthiazide 50/mg, and sodium warfarin 5/mg per day which she discontinued a month later. Her past history included systemic hypertension diagnosed in 1974 and treated for one year only; pulmonary tuberculosis was diagnosed in another hospital in 1975 and treated continuously since with ethambutol and isoniazid.

On her current (second) admission, she was mildly dyspneic at rest. There was no clubbing, cyanosis, or anemia. The pulse rate was 90/min and regular, and the blood pressure 100/50 mm Hg. The jugular venous pressure was elevated 4-5 cm above the clavicle at 90° angle and exhibited prominent "a" and normal "v" waves. The carotid and other peripheral pulses were normal. A diffuse right ventricular systolic heave was palpable over the left lower parasternal region. On auscultation, the first heart sound was normal. The second sound exhibited a narrow split on expiration that increased slightly on inspiration; its pulmonary component was louder than the aortic at the pulmonary area and was audible at the apex. A musical, "honking," late systolic murmur (grade 3/6) was audible at the tricuspid area. Its intensity increased on inspiration, but, in subsequent examinations, its peak intensity was recorded on expiration. In addition, the murmur consistently became louder on standing. There were no ejection sounds, gallop sounds, or diastolic murmurs. Examination of the lungs revealed a few inspiratory basilar

* All authors are associated with the Medical College of Georgia in the following positions: respectively, research fellow in cardiology, associate professor of cardiology and director of cardiac noninvasive laboratory, assistant professor of cardiology, and resident in internal medicine.

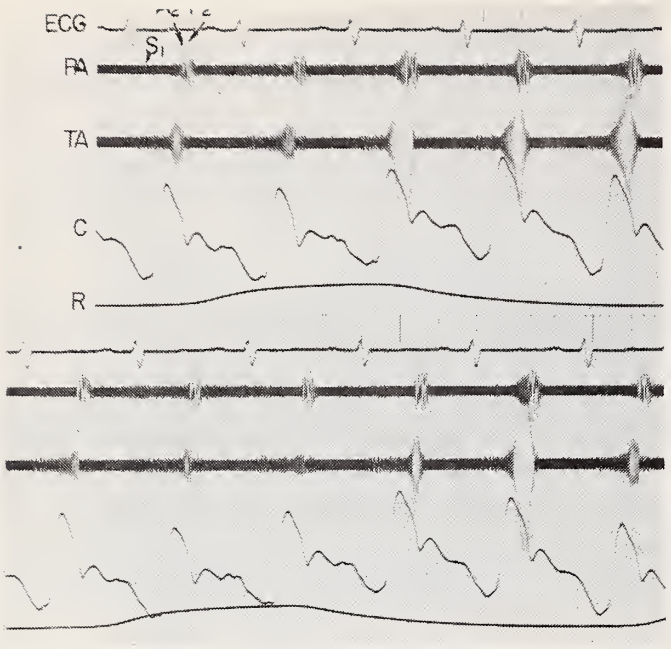


Fig. 1—Case No. 1. Continuous unretouched recording of phonocardiogram from the pulmonary (PA) and tricuspid area (TA), electrocardiogram (ECG), and external carotid pulse (C). In this and the following four figures, a respiration trace (R) which moves upward on inspiration is included. Note the increased intensity of the pulmonary (P_2) relative to the aortic (A_2) component of the second heart sound. Also note that the musical late systolic murmur, best recorded at the tricuspid area, reaches its maximum intensity at peak inspiration on the upper tracing and at peak expiration on the lower tracing a few seconds later. S_1 = first heart sound.

rales bilaterally; the percussion note was normal. Apart from mild liver enlargement with positive hepatojugular reflux, examination of the abdomen was normal. There was moderate pedal edema extending up to the knees. Examination of the remainder of the systems was normal.

The chest X-ray showed moderate cardiomegaly, prominent hilar vessels, and blunted right costophrenic angle. The electrocardiogram showed sinus tachycardia (120/min), low QRS voltage, right atrial and ventricular enlargement, and right axis deviation (+160°). The lung scan revealed multiple bilateral perfusion defects, highly suggestive of multiple pulmonary emboli; in comparison to the scan carried out six months before, there was no significant interval change. The phonocardiogram confirmed the auscultatory findings as reported above (Fig. 1). The echocardiogram showed a mid-late systolic prolapse of both tricuspid valve leaflets; the degree of prolapse increased on inspiration and was proportional to the intensity of the simultaneously recorded late systolic murmur (Fig. 2). In addition, the systolic closure of the valve (point C) was delayed so that transition from point B to C formed a "shoulder" (Fig. 3, white arrow), indicative of elevated right ventricular end-diastolic pressure.[10] The end-diastolic dimension of the right ventricle was increased (36 mm) at the expense of the left ventricle (35 mm), the performance of which was normal (Fig. 4); the mitral echogram was also normal.

On the basis of these findings, the diagnosis made was: multiple bilateral pulmonary emboli with secondary severe pulmonary hypertension and right-sided failure; and prolapsed tricuspid valve with mild tricuspid regurgitation. She was placed on sodium warfarin (5 mg), digoxin (0.25 mg), and furosemide (40 mg) daily, with considerable symptomatic and objective improvement and was discharged on this regimen 10 days later after an eleven-pound body weight loss due to mobilization of dependent edema.

Case Report No. 2

A 46-year-old white woman was admitted to this hospital on August 16, 1976, because of abnormal vaginal bleeding of two years' duration. Endometriosis was diagnosed and a preoperative cardiology consultation was requested because of a history of repeated episodes of electrocardiographically documented paroxysmal atrial tachycardia since 1966, for which she had been on quinidine and digoxin for the past four years.

On examination, she was not breathless at rest. There was no anemia, clubbing or cyanosis. The pulse rate was 82/min and regular, respirations were 20/min, temperature 37.4°C and blood pressure 105/65 mm Hg. The carotid and other arterial pulses were normal, the jugular vein was not distended at 30° inclination, and the hepatojugular reflux was

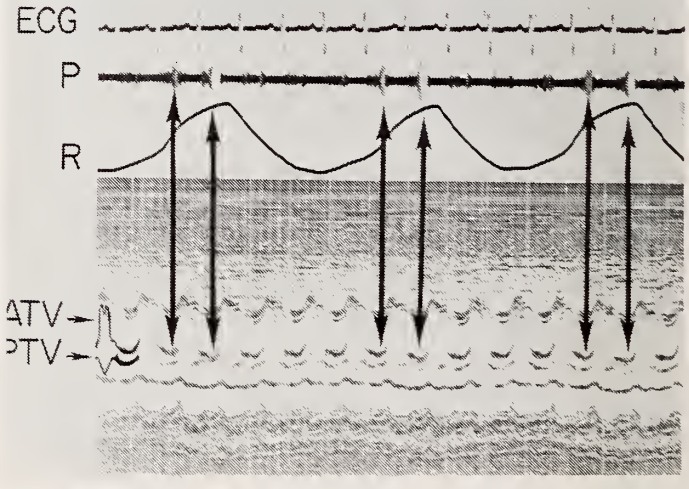


Fig. 2—Case No. 1. Simultaneous recording of the tricuspid valve echogram against electrocardiogram (ECG), phonocardiogram from the tricuspid area (P) and respiration trace (R). The echoes from the anterior (ATV) and the posterior (PTV) leaflet of the tricuspid valve were retouched on the first beat for clarity. Both tricuspid leaflets exhibit a systolic posterior prolapsing movement which becomes more prominent on inspiration, when the late systolic tricuspid murmur reaches maximal intensity (double-headed arrows).

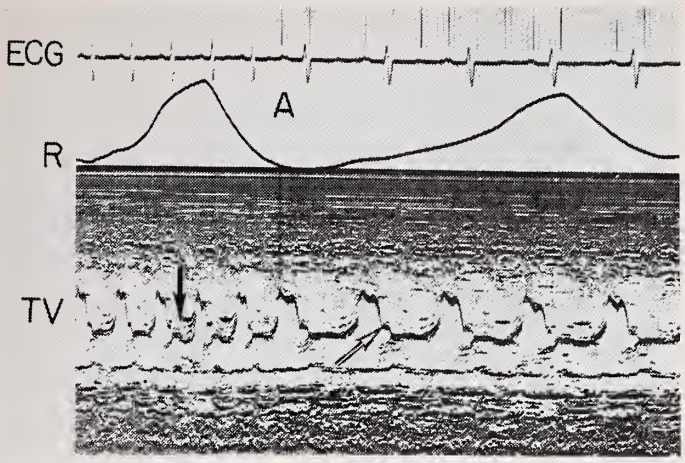


Fig. 3—Case No. 1. Unretouched recording of the tricuspid valve echogram (TV), electrocardiogram (ECG), and the respiration trace (R). The black arrow points to the onset of the posterior prolapsing movement of the tricuspid valve which is most pronounced on inspiration. The paper speed was doubled at point A (from 25 to 50 mm/sec), to permit easy recognition of the "shoulder" created by delayed closure of the valve 60 msec after the point B shown by the white arrow.

negative. The cardiac apex was normal in location and character. Prominent systolic expansions were felt at the pulmonary area. On auscultation, the first heart sound was split; the second sound was physiologically split with the pulmonary component louder than the aortic at the pulmonary area and audible along the lower left sternal border, but not at the apex. A loud atrial systolic S4 gallop accentuated on inspiration, as well as a pulmonary ejection sound followed by a grade 2/6 systolic ejection murmur, were also present along the upper left sternal border. The lungs were clear to percussion and auscultation. Examination of the abdomen was normal, apart from mild suprapubic tenderness.

The electrocardiogram was normal. The chest X-ray showed normal heart size and configuration, normal lung fields and blunting of the right costophrenic angle, not present on a chest film taken five years before. The perfusion lung scan was normal. The phonocardiogram confirmed the auscultatory findings. The echocardiogram (Fig. 5) of the mitral and aortic valve was normal; the dimensions of the aortic root, left atrium, right and left ventricle were normal. The interventricular septum was asymmetrically hypertrophied (15 mm) in comparison to the thickness of the posterior wall of the left ventricle (10 mm), whose performance indices were normal. There was no pericardial effusion. The echocardiogram of the tricuspid valve exhibited a mid-late systolic posterior prolapse (Fig. 5, lower). Total abdominal hysterectomy was successfully carried out and, after an uneventful recovery, the patient was discharged on 800 mg of quinidine and 0.25 mg of digoxin daily.

Discussion

Identification of the late systolic murmur as originating from the tricuspid rather than the mitral valve in our first patient was based on: its location at the tricuspid area; the simultaneous increase in both the intensity of the murmur and the magnitude of the tricuspid valve prolapse monitored by echocardiography (Fig. 2); and the presence of a normal mitral echogram. The tricuspid regurgitation was mild, as suggested by the absence of prominent "v" wave at the neck veins, systolic liver expansion, or paradoxical septal motion on the echocardiogram. The timing of the murmur in late systole and its persistence after significant clinical improvement and marked reduction in heart enlargement indicate that the regurgitation was due to the prolapse of the tricuspid valve rather than to severe right ventricular enlargement and failure, as is commonly the case in clinical practice.

Tricuspid regurgitant murmurs are known to become louder on inspiration.[11] This was not invariably the case in this patient whose murmur exhibited its maximum intensity at different phases of respiration at different times (Fig. 1). Similar departure from the rule was observed by Gooch, et al.[7] in a patient with prolapsed tricuspid valve and a late systolic murmur that reached its peak loudness *after* deep inspiration. The reason for, and the mechanism involved in, this peculiar behavior of the murmur of tricuspid valve prolapse are obscure.

The frequent occurrence of several types of arrhythmia in prolapsed mitral valve syndrome is long recognized.[12–14] Although in none of the six cases

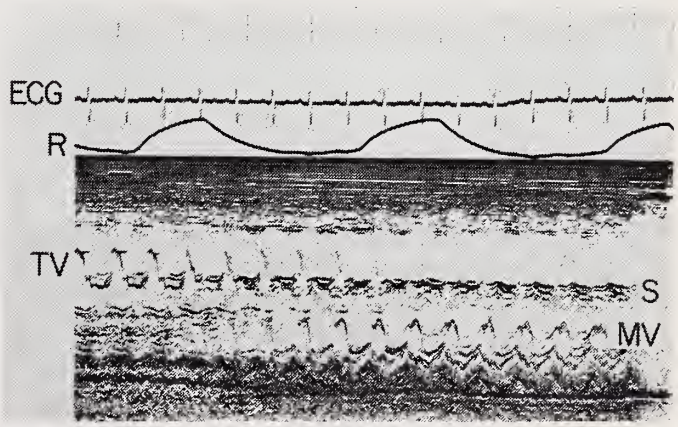


Fig. 4—Case No. 1. Echocardiographic sector scan recorded from the fifth left intercostal space parasternally. The transducer was initially pointed medially and slightly inferiorly to record the tricuspid echogram (TV), and was gradually tilted inferolaterally to record the echogram of the mitral valve (MV) and the body of the left ventricle. A posterior prolapsing movement of the tricuspid valve is obvious, especially on inspiration. Note significant enlargement of the right ventricle, diminished anteroposterior left ventricular dimension and normal mitral valve echogram. ECG = electrocardiogram, R = respiration trace, S = interventricular septum.

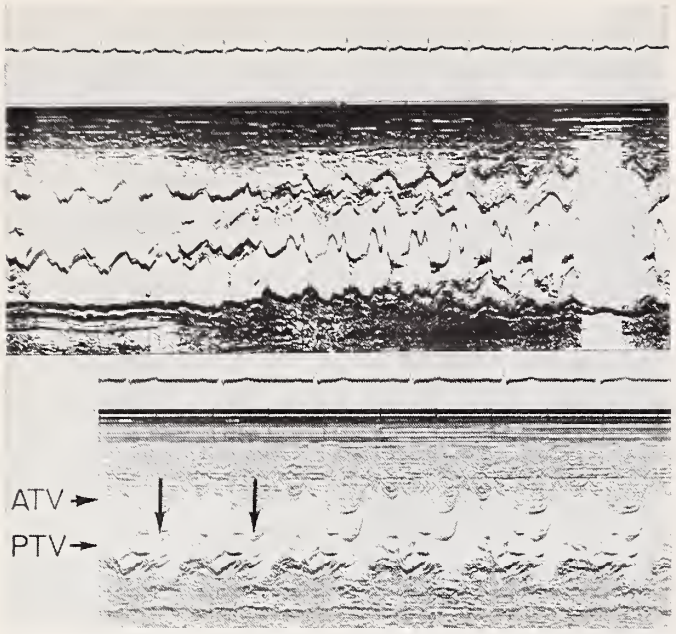


Fig. 5—Case No. 2. Upper: Standard echocardiographic sector scan from the aortic root (left) to the body of the left ventricle (right). Apart from asymmetric septal hypertrophy, this scan is normal. Lower: The tricuspid valve echogram exhibits a mid-late systolic posterior prolapsing movement (arrows). ATV and PTV = anterior and posterior tricuspid valve leaflet, respectively.

with isolated tricuspid valve prolapse reported at present was paroxysmal atrial tachycardia found,[6, 8, 9] the presence of this arrhythmia in our second patient calls for additional cases to be studied before valid conclusions could be drawn concerning its possible etiological association to the tricuspid valve prolapse. Similarly, the small number of patients precludes any statement as to whether the association between tricuspid valve prolapse and pulmonary hypertension observed in our series is causal or fortuitous.

Unless specific symptoms or physical signs of tricuspid valve disease are present, echocardiographic examination of this valve is frequently omitted. This, in conjunction with the inherent difficulty of recording the tricuspid valve echogram in the absence of right ventricular enlargement, may be partially responsible for the currently limited field of diagnostic applications of echocardiography in tricuspid valve disease. Demonstration of tricuspid valve prolapse at cardiac catheterization is also technically difficult and requires right ventricular angiography which is currently reserved for patients presenting evidence of hemodynamically significant tricuspid valve regurgitation. It is therefore reasonable to assume that a strong bias is introduced and partially accounts for the low incidence of tricuspid valve prolapse suggested by the limited number of cases reported. It is recommended that, during routine echocardiographic examination, an effort should always be made to obtain the tricuspid valve echogram, regardless of evidence of tricuspid valve disease. This policy could provide clues to the etiology of arrhythmias of obscure origin and identify patients with tricuspid valve prolapse who may require antibiotic prophylaxis for bacterial endocarditis as previously suggested.[8]

Acknowledgement

We express our appreciation to Mrs. Beryl H. Wilson for her expert technical assistance and to Mrs. Yvonne R. Harrop, who typed the manuscript.

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Prevalence of Tobacco, Marijuana, and Alcohol Usage Among High School Students: A Local Survey and Comments on Current Patterns of Usage

EDUARDO MONTANA, M.D., F.A.A.P. and CONOR O'NEILL, M.B., B.Ch., *Rome**

THE PURPOSE OF THIS SURVEY was to determine the prevalence of tobacco, marijuana, and alcohol usage among high school students in the city of Rome, Ga., to compare our results with similar surveys in other parts of the country and, hopefully, to suggest new approaches for prevention.

Youth Population Under Study

Rome is a middle-size, semi-rural community located in the northwest corner of the state. The high school population under study consisted of 2,000 students from grades 7 to 12. One-third of the sample attended a private preparatory school and the remainder attended the local public school system, a racially integrated population of middle- and low middle-class extraction.

Method

The survey was done by the confidential questionnaire method (see sample). The original questionnaire, lengthy in order to obtain a close picture of family environment and parental influences, with questions such as "Do your parents and/or siblings smoke," was modified to satisfy reservations from the local school board. Without previous notice or discussion with the students, the questionnaire was administered by one of the authors.

We are obviously concerned about the limitations and validity of this type of survey in regards to the seriousness of the students' answers; however, we consider this direct questioning an accurate method to discover trends of usage.

* Dr. Montana is clinical assistant professor of pediatrics, Medical College of Georgia, and Dr. O'Neill is senior resident in family practice, Floyd Medical Center. Dr. Montana's address is 321 West 10th St., Rome, Ga. 30161.

Small and medium size communities do not greatly differ from the national spectrum of prevalence

Results

Twenty-seven questionnaires were eliminated from interpretation due to several reasons. Twenty students refused to participate in the study and six were blatant in faking or joking about the questions. (One student filled in the blank after "Sex" with "Once in a while.")

Answers to questions 8, 9 and 10 were mostly candid, but some were pedantic or frankly hostile. Students themselves were later approached by one of the authors, about their opinion on the validity of the answers and their overall impression was: "Yes, with that questionnaire you can get a pretty good idea as to what is going on in town." Of the 1,973 tabulated questionnaires, 1,019 were boys and 954 were girls.

The answers to questions 1, 2 and 3 explored "occasional" use (see Table I). Percentage of *boys* using tobacco was 23.45%, marijuana, 25.47%, and alcohol, 45.59%. Percentage of *girls* using tobacco was 22.22%, marijuana, 18.18%, and alcohol, 31.86%. No statistical difference was found between private and public school students, except perhaps that private school students in the lower grades (7th to 9th), reported more alcohol consumption (see Table 2).

The answers to questions 5, 6 and 7, trying to determine "daily" use of the drugs (Figure 1) gave the following results:

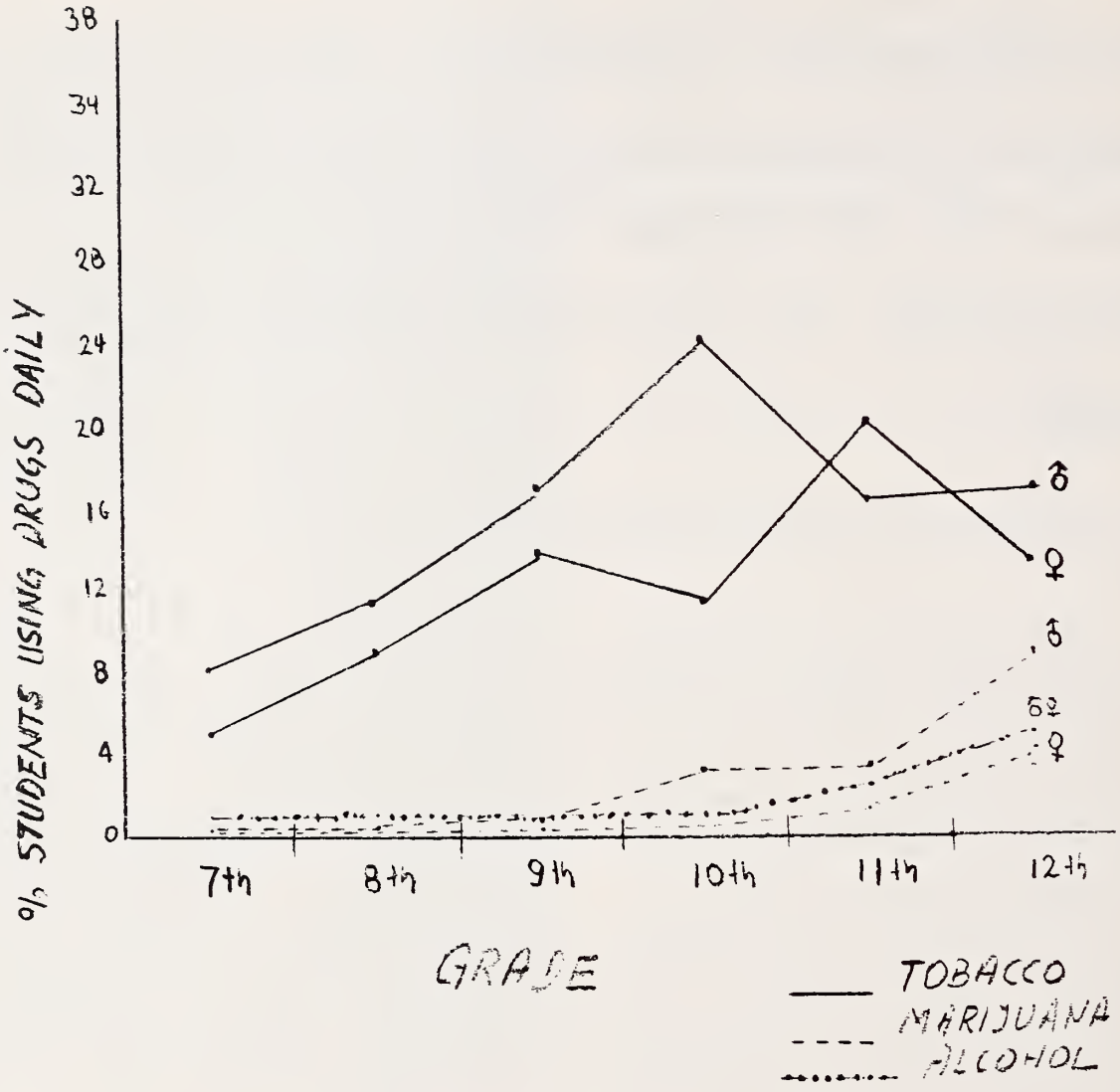


Fig. 1—Incidence of Daily Use of Drugs

Daily Usage	*Boys %*	*Girls %*
Tobacco	20.0	16
Marijuana	8	6
Alcohol	4	3

The answers to question 4 showed that the average beginning age for cigarette smoking in our series was 12 to 13 years of age (about one year earlier in girls). For marijuana and alcohol, the average beginning age was 13 to 14 years, with no sex difference.

In regard to questions 8, 9 and 10, the most frequent reasons given for use of these drugs were adult example and audio-visual influences. The preferred recommended approaches were audio-visual and panel discussions.

Comments

Although the use of hard drugs, heroine, cocaine, LSD and amphetamines seems to be stabilizing among the young, with more fluctuations in large cities, the use of alcohol, tobacco and marijuana seems to be taking strong hold among high-school students. In regard to marijuana, the 1972 Marijuana Commission compiled a file of 200 surveys finding that 15% of high-school students were using the drug.[1] A recent survey by L. Johnson, from the University of Michigan,[2] showed an increase of 5% in the use of marijuana by high school seniors. Our marijuana figure, combined for boys and girls, was 22.04%, which is very close to the figure reported from other states.

The American Academy of Pediatrics[3] has sounded the alarm on the consumption of alcohol by youth, noting that there has been a significant increase in alcohol-related traffic accidents involving teenagers. The possible additive effects of combined use of alcohol and marijuana on driving performance are being

TABLE 1

INCIDENCE OF DRUG USE BY GRADE AND SEX

Grade	Total No. of Students	Sex Distrib.	Tobacco %	Marijuana %	Alcohol %
7th	242	Boys 125	17.51	8.80	13.51
		Girls 117	17.08	4.27	5.12
8th	353	Boys 173	17.91	10.98	22.54
		Girls 180	12.77	5.00	12.77
9th	391	Boys 190	21.56	20.00	37.86
		Girls 201	24.37	32.83	32.33
10th	367	Boys 191	31.93	32.98	51.30
		Girls 176	23.85	18.18	39.20
11th	321	Boys 187	25.13	26.73	55.61
		Girls 134	32.83	26.11	49.25
12th	299	Boys 153	23.52	40.52	68.62
		Girls 146	23.28	23.97	51.36
Total	1,973	Boys 1,019	23.45	25.47	45.59
		Girls 954	22.22	19.18	31.86
		Both 1,973	22.80	22.04	37.35

TABLE 2

COMPARISON OF INCIDENCE OF DRUG USE BETWEEN PUBLIC AND PRIVATE HIGH SCHOOL STUDENTS

Grade	School	Total	% Boys Answer Yes to: Tobacco	Marijuana	Alcohol	% Girls Answer Yes to Tobacco	Marijuana	Alcohol
7th	Private	58	0.34	0.00	8.88	25.00	0.00	0.24
	Public	184	23.07	12.88	15.38	15.05	5.30	5.37
8th	Private	64	5.71	0.35	42.85	6.89	0.20	13.79
	Public	289	21.01	13.04	17.39	13.90	5.30	12.58
9th	Private	77	19.51	17.07	56.09	37.00	8.33	52.67
	Public	314	22.04	20.80	32.88	23.63	18.18	27.87
10th	Private	82	33.82	44.06	69.49	56.52	26.08	60.86
	Public	285	31.06	28.03	43.18	18.95	16.99	35.95
11th	Private	95	31.14	32.78	67.21	51.35	40.54	75.66
	Public	223	22.22	23.80	50.00	25.77	20.60	39.17
12th	Private	126	27.77	47.22	77.77	38.88	33.33	40.21
	Public	173	19.75	34.36	60.49	14.13	18.47	41.31

investigated and could account for some of that increase.[4-5]

In regard to tobacco smoking, teenage usage has shown a 6% increase from 14% in 1965 to 20% in 1976.[6] Our own figure of 22.8% is close to the national percent.

Conclusions

Consequently, we could conclude that small and medium-size communities do not greatly differ in the national spectrum of prevalence. One reason for this could be in influence of audiovisual media and other methods of communication.

Students themselves agree that the most influential factors are audio-visual and our experience in educational campaigns[7] seems to confirm that fact. The role of the primary care physician should be one of stimulating, honest, factual dialogue. Family practitioners and pediatricians are in a privileged position to advise teenage girls about the effects of cigarette smoking on the fetus.[8] When the pregnant social-drinker young woman comes to the obstetrician for care, it may be too late to prevent the now well-defined "fetal alcohol syndrome!" Another original approach suggested by S. James in Atlanta,[9] should be emulated: at the time of their first child's birth, parents are given information about the harmful effects of smoking and the importance of parental influence in establishing healthful patterns for their children to follow.

Other aspects of the problem, such as strict laws for driving a car under the influence of alcohol and/or marijuana, should be explored. In the words of Dr. S. Gellis,[10] "Nothing is more important to the adolescent or adult in our culture than the freedom to drive a vehicle in our highways. If we would en-

force our driving laws, as do the Scandinavians, not only would excessive use of alcohol show a decline, but death on the highway would follow suit. It is unfortunate that we have to legislate against addiction, theft, arson, and all the other evils of our society, but no one seems to come up with more effective alternatives."

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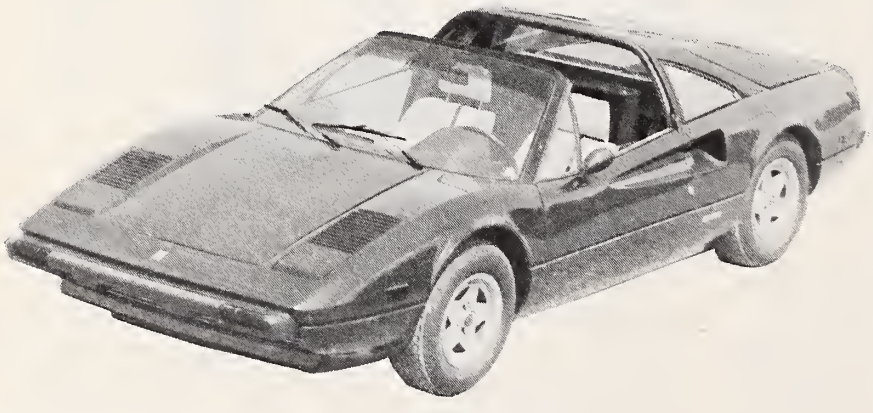
ALCOHOL-TOBACCO-MARIJUANA SURVEY

Dear Student,

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Your candid answers to the following questions are appreciated. Your answers are ABSOLUTELY CONFIDENTIAL, and VOLUNTARY.

Age ..... Sex ..... Grade .....
1. Do you smoke cigarettes? Yes.... No....
2. Do you smoke marijuana? Yes.... No....
3. Do you drink alcohol? Yes.... No....
4. If the answer to any of the above is yes,
   At what age did you start smoking cigarettes? .....
   smoking marijuana? .....
   drinking alcohol? .....
5. Cigarettes—Do you smoke daily? How many .....
6. Marijuana—Do you smoke daily? Sometimes .....
7. Alcohol—Do you drink daily? Weekly? .... Sometimes ....
8. Of the following factors, which ones do you consider important in your decision to drink or smoke:
   Pressure from friends?
   Adult example?
   Because is "in"?
   TV Movies? Other Reasons
9. Which of the following do you consider important in Youth Education about drugs?
   Panel discussions?
   Booklets?
   Audio-Visual?
   Others?
10. Comments or suggestions? .....
    .....



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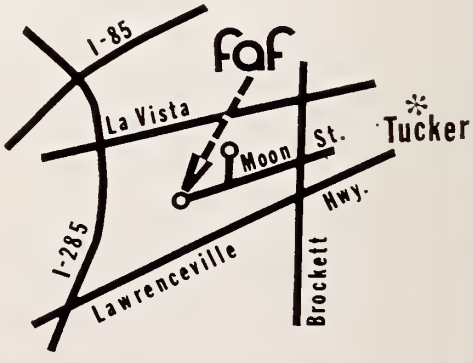
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The author, traveling as a member of a delegation of the American Cancer Society, makes some thought-provoking observations.

Medicine in the Peoples Republic of China

A. HAMBLIN LETTON, M.D., F.A.C.S., *Atlanta**

The Peoples Republic of China recently requested the American Cancer Society to send a delegation to China to evaluate their cancer control efforts. It was thus that I spent 21 days in China as a guest of the government of The Peoples Republic of China. There were 19 of us in the delegation, all of different disciplines. Mrs. Robert Huff of Rome, Georgia, a former vice-president of the American Cancer Society, was with us because of her expertise in public education. Others were scattered from over the United States.

Upon arrival, each two of us were assigned to a private car with an interpretor and a driver. We were taken to see their institutes, hospitals, clinics and even into the fields where the barefoot doctors were working beside the peasants. My interpretor was Dr. Ha, who is Chief of Head and Neck Surgery at Peking Tumor Institute.

There were no restrictions placed on us. We were taken to see anything that we asked, and questions were answered without hesitation. I am sure that we saw their best but nothing was being hidden as far as we could determine. Possibly we were brainwashed, but it wasn't as obvious as it is in Russia. The people are hardworking, happy and living without fear. Mao is almost a religion. He has made great changes in the lives of these people. Patriotism and the working for the good of all permeates their every thought and action. Mao's dream of a society in which no person rises above the next, in which patriotism and the good for the whole is substituted for personal gain is almost a reality. To understand this (and, at times I have trouble in understanding it), one must remember "Capitalistic China" before liberation with its cruel landlords. The people remember those times of losing their land when they could not pay their debts. They remember eating chaff, grass and the bark of trees to stay alive. They also remember their children being sold into slavery —their daughters as concubines. Mao brought them out of all of this. He is their hero, almost their God. Now, they know they have a home, a job, enough to eat, medical care, and pension when they retire. They are happy and hardworking, trying to have an even better country. They have made great progress in these 28 years.

All of the people belong to some type of production team or neighborhood group who have group discussion sessions in which everyone is discussed and criticized. Any transgression is noted and the transgressor is criticized and "talked to" to "re-educate" him. There apparently is no reprisal. They do have jails, but this is for the murderers. Crime is at a very low ebb. There were no locks on our hotel rooms. It is safe to leave anything; it will always be there when you come back. One lady in our group had a run in her pantyhose. Everytime she left a hotel, somebody brought the pantyhose out to her in the car. It took five hotels to get rid of them! Even the "Gang-of-Four" who have tried to take over the government during Mao's illness and especially after his

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death, are now only under house arrest. I saw many things, we heard many things; we don't understand all!

Health Delivery

Due to regimentation of the masses, the health department is able to do mass immunization and educational programs. Paramedics who provide health education and give simple medical care are known as "barefoot doctors" in the rural areas and "red medical workers" in the cities, and are able to take health education and medical care to the peasant or worker at the grass root level. The city doctors are sent to the rural areas for six months or a year and provide guidance to the little hospitals and their personnel, as well as give the refresher courses to the "barefoot doctors." Thus, the health care system has a representative rubbing shoulders with the workers or peasants on a day-to-day basis. It is through these paramedics getting the sick treated early in the disease that China has made such progress in the health field in the last 28 years.

The chiefs of many of their institutes were American, British or European-trained. Dr. Geo Woo, the leading radiotherapist, is from North Carolina. Dr. Li spent five years at Memorial Hospital in New York City. Dr. Haitem was European trained, etc.

Our travels were not only in Peking, but to Linhsien County and Yao Village, to Shanghai, to Canton and to Quai-Lin, then back to Peking before coming home. It was in these various areas that we visited not only their best research institutions, their tumor hospitals, their regular hospitals, their clinics, their filter stations, but even visited with the "barefoot doctors" and the "red medical workers" at their place of work. And, thus, we were able to see how this all integrated and how they were doing a tremendous job of caring for the sick under very primitive circumstances.

Cancer of the Esophagus

Fifty percent of those people over fifty years of age in Linhsien County, which is some 300 miles southwest of Peking, die of cancer of the esophagus. Dr. Lei, the chief of surgery of the 250-bed county hospital there, operates on two cancers of the esophagus every day. Because of the prevalence of this disease, mass screening for cancer of the esophagus is done on everyone over 30 years of age. The "screenee" swallows a small fishnet-covered balloon on a rubber tube. The balloon is distended and pulled back up through the esophagus, and the fishnet collects surface cells which are used to make Pap smears. Eighty-six thousand peasants have been screened and 2,392 cancers of the esophagus have been found, of which 1,018 were "early." They now have 207 early cases with a 90.3% five-year survival and an operative mortality of 3%. On the advanced cases, they use preoperative irradiation and then surgery, and have a 33.7% five-year survival for over 1,000 patients. They plan to mass screen the peasants every three to four years.

When a positive Pap smear is found, the patient is esophagoscoped with a fibro-optic scope. The surface is stained with Toluidine blue dye to help identify the lesion. The lesions are too small to be felt at the time of surgery.

An extensive epidemiological study was done, which included a study of the peasants' eating and other personal habits, along with an analysis of their food and the environment. It was noted that the chickens and pigs in this area also have an increased amount of cancer of the esophagus. The people in this area eat a large amount of pickled vegetables, there being no refrigeration at present. Studies indicate the nitrate content of the saliva and urine among these people who eat the pickled vegetables is much higher than in the provinces where there is little carcinoma of the esophagus. The pickled vegetables contain nitrate which the gastric juice converts into nitrosamine, which is a known carcinogen. Public education programs to warn about the harm of eating pickled vegetables are under way. We

"The people are hardworking, happy and living without fear"

stopped at a brigade school where children were putting on a performance for their parents with singing and dancing and their own orchestra. This performance was totally concerned with the harm of eating pickled vegetables.

They are also having the peasants take large doses of Vitamin C in hopes of oxidizing the nitrosamines into a harmless by-product. Over 9% of those patients with hyperplasia not taking Vitamin C develop cancer while only 2.3% of those on Vitamin C develop malignancy. There is also a lack of molybdenum and fluorine in the soil, so they are adding these to the fertilizer. A fungus similar to Candida is found in the grain as well as in the cancer. They do not know whether it is a contaminant or a causative agent, or, whether it, along with the nitrosamines, has a synergistic carcinogenic action. At any rate, they are making efforts for better storage of grain. This program is only three years old at this time and the results are not yet determinable.

Since these people in the communes usually stay in the communes and are not a mobile people, they have been able to trace back through eight genera-

tions, and do not feel that this is a genetic problem. They are also doing chromosomal studies on them. They do find that there is a change in the chromosome in those people with carcinoma of the esophagus, but, again, they do not feel it is an inherited trait.

Cancer of the Liver

Cancer of the liver is quite common in some of the larger cities, particularly in the Shanghai area,

"I am not sure that our system would work for them at this time"

so much so that they are doing mass screening of the workers using alpha feto protein as a biomedical marker. They report the incidence of cancer of the liver is 10/100,000. A "drop" of blood is taken from the workers in the factories and tested for alpha feto protein. Whenever there is an increase in AFP, the patient is brought into the hospital for liver screening and angiography. If the lesion is discernible, it is operated. If these tests are negative and the AFP continues to rise, the patient is explored. They report on 50% five-year survival of "small" lesions. They claim the AFP test costs about three cents. The coordinating research group made up of biochemists, parasitologists, immunologists, geologists, geneticists, clinicians, geochemists, geographers, etc., have not delineated the causative factors in carcinoma of the liver, but they feel that liver flukes and schistosomiasis is not the causative agent. Seventy percent of the liver cancer patients have cirrhosis.

Carcinoma of the Stomach

The incidence of carcinoma of the stomach is not as high as in Japan, but is much higher than in the United States. Screening is done in high incident areas (in the northwest, northeast and central coastal cities), using the tetracycline test which seems to be rather reliable in their hands.

One-half gram of tetracycline is given orally and, two hours later, a blood sample is drawn. When a quantity greater than one gamma per cc. is found, it is considered positive. The positive responders are then brought in for X-ray and gastroscopy examinations. Eighty percent of the positive tests have been found to have carcinoma of the stomach. They also use sialic acid. Values over 50 mg % are considered positive. This, also, gives a positive for cancer of the lung, 86% true positive. The normal is only 13% where adenocarcinoma of the stomach is 78% and an undifferentiated carcinoma of the stomach is 97%.

Nasopharyngeal Cancer

At the Tumor Hospital in Canton, 3,000 new cases of nasopharyngeal cancer are admitted each year. They have two Cobalt machines and three 250 K.V. Radiotherapy machines. The "Gang-of-Four" stopped the manufacture of the linear accelerator, but this has been restarted and they hope to have it sometime within the year. Their radiation equipment is working 24 hours per day, seven days a week, giving radiation treatments to these patients. Mass screening of the peasants and workers is underway, using Pap smears of the nasal secretion. No etiological factor has been isolated by the coordinating working groups at present.

The volume of cases is so large that their facilities are overtaxed, and, therefore, experiments with arterial perfusion with various anticancer agents is underway. These procedures could be done in the smaller hospitals who do not have radiation equipment, thus lightening the load on the already overworked radiation equipment and personnel if such treatment proves beneficial.

Exportable goods from the Republic of China, is, as yet, so small that they are unable to purchase all of the radiation and other technical equipment which

"The fact that they do not have personal freedom . . . doesn't seem to bother them at this time"

they desire. They, however, are copying some of the Canadian equipment, but it is still in woefully short supply.

Cancer of the Breast

This cancer is of much less incidence than in the U.S. being about 0.2 per thousand and this is not a big problem except that, when it is discovered, it is usually late. We saw several Stage III cancers of the breast which are being treated with intra-arterial infusion using 2,050 mg 5 FU, plus 2,000 mg Cytoxin over a 20-day period. These were followed by irradiation and then by surgery and they report a 22% five-year survival rate by surgery alone and a 36% five-year survival rate with irradiation plus surgery, and a 57% five-year survival with arterial infusion of chemotherapy, irradiation and surgery.

Cancer of the Cervix

Two hundred and fifty thousand women in the Shanghai area have been screened for cancer of the cervix in the last fifteen years. At first, the incidence of carcinoma of the cervix was 91 per 100,000 and

because, in the meantime, the pre-cancerous lesions have been treated, the incidence is now only 34 per 100,000. Mass screening of these women is being done in the women and child welfare departments. Large scale screening of all of the population, has, as yet, not been done because of the magnitude of the problem. Treatment for Stage I carcinoma of the cervix is the typical Wertheim operation. We saw several Stage III carcinomas of the cervix treated by intra-arterial infusion with the catheter into the hypogastric arteries bilaterally, followed by radiation. They report a 52.5% five-year survival with the radiation alone and a 72.7% five-year survival with radiation plus systemic 5 FU. For four years, the infusion has been used on 26 patients and, at present, all of these are living.

Cancer of the Thyroid

Cancer of the thyroid apparently is a little more common in China than in the U.S. In our practice, we have found carcinoma of the thyroid in 11.3% of the 2,000 consecutive thyroidectomies which we had done up until a couple of years ago.

The rate in China is about 18%. It may be that because of the crowded conditions at their hospitals, they do not operate on as many of the nodular goiters unless they have a high suspicion of malignancy.

Their methods of therapy are essentially the same as ours and their survival rates match ours for the various stages. They do most of their thyroidectomies under acupuncture anesthesia. They claim this helps them in preventing injury to the nerve. My own contention is that you don't have voice change until after you have injured the nerve.

Schistosomiasis

Schistosomiasis has been a major problem among the peasants working ankle deep in the water in the rice fields for many centuries but by concerted effort, this is now almost eliminated. This was accomplished with the combined efforts of many, many people. The canals were cleaned of all their weeds and reeds by the children working after school, and, thereby destroying the habitat of the snail. The night soil is being stored in closed containers so that it ferments, producing heat which kills the ova and parasites and, also, gives off methane gas which is stored and later used for fuel. The peasants' stools are being examined for ova and parasites twice each year by the "barefoot doctors" and infected patients given treatment.

Re-Implantation of Limbs

There is no OSHA in China. Little care is taken to protect workers from accidents. Many arms, legs, fingers, etc., are severed by machinery or in other accidents. In Canton, one surgeon has re-implanted 110 limbs with 89% success. He practiced using the operating microscope on mice to perfect his technique. I saw one man whose thumb had been re-implanted 48 hours previously. One artery, two veins, and two nerves had been sutured together. A pin was placed in the bone. The thumb looked good, a normal pink and a good blood supply. He showed us a case of chondrosarcoma of the shoulder on which he had done a forequarter amputation and then the arm had been amputated from the shoulder at about the level of the mid-humerus. An artificial shoulder joint had been put in and the arm re-implanted with the vessels and nerves joined. We saw the man. He had a very short arm but had good function of his hand, wrist and elbow.

Acupuncture Anesthesia

Anesthesia with acupuncture began in 1959. Two million operations of 100 different kinds have now been done, using this type of anesthesia. In the chest cases which we saw, the needles were inserted in the front and the back of the chest on the side to be operated and connected to a galvanic current of 200 cycles per minute at five milliamps. The third needle was inserted into the dorsum of the forearm on the same side some five inches above the wrist and was twisted by hand at about 150 cycles per minute. They claim that the needle twisted by hand is better than electrical stimulation, but the needles are out of reach of the anesthetist and, besides, he has but two hands to twist the needles. In some 15 minutes, 70 mg of Meperadine were given intravenously and five minutes later, the chest incision was made. The patient, who was awake and responded to questions, was apparently in no severe pain. Some novocaine was used when cutting the large intercostal nerve. One of the patients occasionally grimaced as if she had some pain. One of them had an endotracheal tube introduced under local because of increased secretions. The others did not and were just given some positive pressure breathing with a mask on occasion. There was no cyanosis noted in any of these patients. A patient with cancer of the thyroid had needles inserted into the volar surface of the forearm, four inches above the wrist bilaterally and then four needles were inserted between the eyebrows on the forehead. These were all connected to the same type of electrical current. The patient had received sodium luminal and atropine preoperatively and, some 20 minutes later, the incision was made. No novocaine was used. The patient was awake and talking and in no apparent pain.

They apparently choose their patients and their op-

erations for acupuncture anesthesia very carefully.

We saw acupuncture being used in menstrual disorders. Needles were placed in the ear, being twisted for about 15 minutes, once each week and this was supposed to take care of all sorts of menstrual disorders.

Burns

We visited the Burn Center in Shanghai. They average receiving between two and 300 major burns every year. By major, I mean over 60% of the body area has been burned. They are using some herbs which have tannic acid in them. They talk about free tannic acid and combined tannic acid probably hooked on to a polypeptide, according to my understanding. They say the combined tannic acid is not toxic, yet makes an eschar which prevents the escape of fluids, helps them maintain fluid much better and prevents infections from getting into the burn. After five to six days, the eschar is surgically excised and a graft is placed on the site. Because of the massiveness of these burns, they are using heterografts or pigskin grafts. These grafts are stored in liquid nitrogen. The temperature is lowered gradually, first in a refrigerator, then into a deep freeze, and then into a liquid nitrogen, this entire process taking some 24 hours. To use the graft, it is placed in a 40° centigrade waterbath. When the graft is applied, there are small slits made in it and, as it is stretched out over the burned area, these slits become little holes. Then a split thickness graft of some of the skin from the patient (we saw them taking a skin graft from the scalp after the head had been shaved) is cut into small one-centimeter squares and placed in the holes in the heterograft or pigskin graft. As the graft takes and gradually grows under the heterograft, the latter is desquamated. This keeps the raw area covered at all times and prevents infection. Their rehabilitation clinic is quite good and they had these people with severely burned arms and legs moving within a matter of two weeks time.

Summary

We saw and heard many things which we are still pondering. Here is a young nation with over 900,000,000 people (one-quarter of the world's population) where only 12% of the total land area is tillable. It is pulling itself from a feudal serfdom by its own boot straps, trying to compete with the industrialized nations of the west. Their progress is remarkable; they are performing good research, finding disease early and giving good treatment, in almost primitive type conditions.

The greatest hurdle toward understanding that our people and their people seem to have is that we are known as "capitalists" and they remember their miserable lives under the so-called "capitalism" while we think of them as "communists," forgetting that our own use of the word "communism" includes the fear, the secret police, the people disappearing at night, and the desire to rule the world as demonstrated by the Russians. These are different people from the Russians and they speak of Russia as their main enemy.

They are happy people. Fear does not ruin their lives. Their system is providing the immediate needs. The fact that they do not have personal freedom to do as they please or what they find necessary to do doesn't seem to bother them at this time. Whether their system will sustain them in years to come remains to be seen. I am not sure that our system would work for them at this time. I do know that I don't think their system would ever work for us in the U.S. and that we must constantly guard against the gradual encroachment of socialism in our government.

We had a one and one-half hour audience with Vice-Chairman Hu Lan Fu in which he emphasized the necessity of settling the Taiwan problem and implementing the Shanghai communique. From what I saw, it seems to me that we should have a normal relationship to this country with one-quarter of the world's population.

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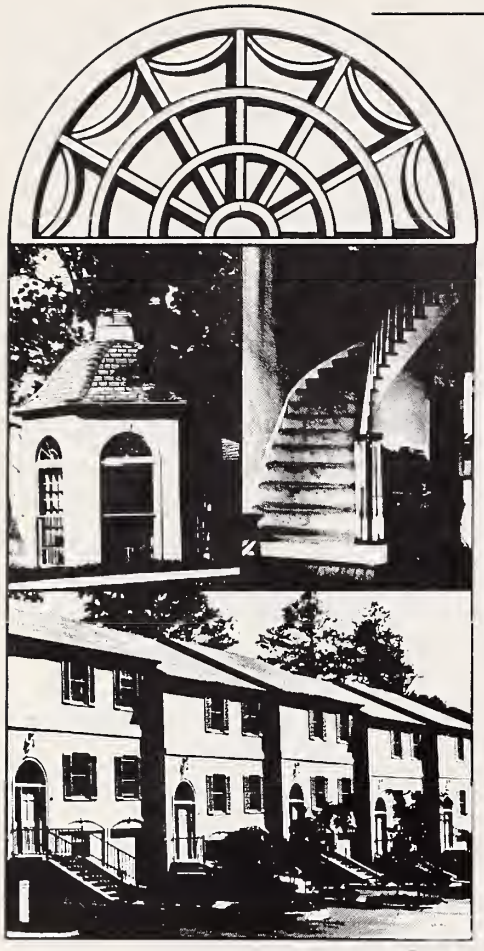
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A philosophic discussion of the evolution of dermatologic practice over the past 45 years

The Ordeal of Change in the Practice of Dermatology

HERBERT S. ALDEN, M.D., *Atlanta

To be asked to speak before one's peers, especially to those most actively engaged in what one might call the "changing order," is both an honor and a pleasure which cannot be evaded nor denied.

But having chosen my subject, or better, having in a sense borrowed my title from one of America's most respected "waterfront" philosophers, Eric Hoffer, I have become increasingly disturbed lest the phrase, "The Ordeal of Change in the Practice of Dermatology," might be construed as a painful, disagreeable or even bitter experience. Such is not the case because, for me, this "ordeal" has been pleasurable, exciting, and sometimes enthralling over the last 45 years. It is not unlike an unanticipated sexual experience, leaving one pleased, somewhat fatigued, but completely fulfilled with the great hopes and expectations for similar ordeals of the future.

The misanthropy of the old is due in part to the loss of that magic glow of desire and sensuality which accompanies age so that, after nearly a half century of the practice of medicine, it might be easy to fall into the trap of reminiscence with its tiresome repetition that accompanies such narratives. But it is also wise to recall that he who has not heard nor read history and does not heed the lessons of the past may be condemned, as was Sisyphus—to push a heavy load up a steep hill only to have it slip back and then forever repeat his efforts. "He who is disposed to ignore history must be prepared to repeat it."

I could regale you with many experiences of the past 50 years, which at the time were considered normal or average, but now in hindsight smack either of neglect or of sometimes the ludicrous, experiences such as: my first attempt at circumcision and plastic surgery as a junior medical student; the deaths, convulsions and exfoliative dermatitis resulting from the treatment of syphilis with arsphenamines; the extensive and disastrous effects of bacterial and virus infections in which death was an almost inevitable conclusion for such diseases as smallpox, septicemia, pneumonia, and tuberculosis; the early experiences with sickle cell anemia with its leg ulcers and the use of maggots (fly larva) as a cure; the dermatology clinics at Grady Hospital with 25% of cutaneous syphilis; the pyodermia and the scabies; the use of sulphur with its odors and of benzyl benzoate; the intense drama accompanying the first use of sulfanilimides; the first use in the second World War of penicillin; the use of tetracyclines for acne, and the dramatic change in dermatology treatment with the hydrocortisones.

I have witnessed the insidious rise of the third party in the payment for health care, the economics of medical practice or the rendering of medical service under the increasing power and influence of the labor unions, the crucial and creative role of the drug industries, the role of technology in the practice of medicine, the changing demographic spectrum and the challenge of the unstructured leisure of the people, the seeming derailment of reason and the loss of medical judgement, the rise of the myth of equal results because of equal rights and, finally, the fear of being oneself because of the antagonisms and legal suits and exaggerated claims of disease and its consequences. All of this seems to have made Pharisees of us in the medical practice. (Note: The Pharisees are one of three Jewish sects noted for their self-conceit, their long prayers, their unnecessary tithes, their broadening of their phylacteries, and their tight hold to tradition.)

But all of this is not the crux of the question. I would like to bring something deeper and broader to you in this ordeal of the changing world in medicine.

We are, in spite of ourselves, inheritors of a social sort of Darwinism so ably espoused by Spencer in the 1870's: that the survival of the socially fittest will occur

* 3316 Piedmont Road, N.E., Atlanta, Ga. 30305. This paper was presented at the 1977 Annual Meeting of the Georgia Society of Dermatologists.

wherein we believe we must compete with each other in any manner and in any way in which we see fit, right or wrong, in a mere struggle for existence and economic security. We are also inheritors and executors of the cult of specifism and etiology disease and its therapy in which medicine was deliberately and invariably fixed on disease and not on health. The discovery of bacteria led us to the dynamic conception that, if there was a specific disease, there was a specific cause and a specific cure. Thus was born the idea of the magic bullets and doctors have become more concerned with health in a negative sense as an *absence* of disease. This concept of disease in its simple form was, and is now, popular among physicians as well as among the laity. Conventional wisdom believes that one discovers the malignant agent of disease through some magic bullets or some wonder drug like a modern guided missile finds the noxious agents, destroys them, eliminates disease and produces its corollary health. As an example, note the reports on the cure of cancer by chemotherapy. Such conventional wisdom may have been comforting philosophy at the beginning of the twentieth century when Sir William Osler was singing "man's redemption of man" by the conquest of disease, but it will not answer the medical problems of the 1970's.

The dermatologist is not, as contemporary wisdom would have us believe, the logical result of scientific progress. He is a negative practitioner of medicine in that he does not practice comprehensive medicine. In spite of our humble beginning and maybe because of it, we specialists tend to have an illusory feeling of superiority which is not founded on fact. Diseases have not been conquered by the clinical and surgical specialists, but by the ecologists, the physiologists, and the sanitary engineers. We only use and improve on their discoveries. In effect, the conquest of disease has produced a partial death of many specialties. Where is the syphiologist today? The surgeon that depended on the repair of the ravages of gonorrhea? The surgical otologist? Dermatology, one of the earliest specialties, lost more ground than most and now must practice cutaneous medicine. It is true that the specialist has sought to bolster himself with his training and ability by the self-imposed examinations, letters of abbreviations that sound like degrees of education, and by the device of the medical specialty boards. For self-protection the doctors have developed "group practice." Group practice is not great medicine but more like another example of "togetherness" so often extolled by the modern organization man and it leads to conclusions in which one takes the "rap" or to "cookie-cutting conformity," to a place where the positive power of the "lone think" is lost.

It is quite clear that these changes have been brought about by great social and economic upheaval in which the medical profession as such has counted for very little in the final result. We physicians could not, and cannot, do but very little to alter the social and economic changes now taking place.

However, there is one area in which the medical profession has in the past and now can exercise great influence. This is in medical education. Progressive medical education must teach the medical student of the day and the terms of the changing order of the times and not the terms of what he was or that which he is to be. The teacher can only partially equip him to meet the responsibility and obligations of the future. The medical faculty must in the broad sense take in the student what it can get, not always what it wants. We may have to follow the lead of big business and choose students for their interest and enthusiasm, rather than their experiences in biology and chemistry or for their high scholastic grades.

The haste of enlarging medical education, however, only mirrors a haste in the equality of opportunity in general education. This rapid and progressive education may have delivered quantities of information to quantities of people but seems to have succeeded only in producing a generation of mental slatterns. The student, both medical and otherwise, seems to be literate only in a formal sense. He is capable of putting the letters "CAT" together to form the word "cat" but he is not literate in the sense that he is able to derive from these letters any clear medical concept of the animal itself. The diagnostic group unwittingly becomes guilty of the ancient abdication of reason, the heresy that to *name* is to *know* but giving a name or spelling out a diagnosis is only the beginning of wisdom and learning. not the end. This is a special fault of the dermatologists who often seem to have never escaped from the ancient priesthood position of belief that *naming* a disease gave *control* of the disease. Sometimes it seems we have lost sight of the student's soul and his imagination and neglected to teach clinical judgement. This lack of clinical judgement I think may have prompted a remark from a junior medical student who, coming out of a medical lecture, appeared to be a bit put out. I asked him how the lecture had gone.

"Diseases have not been conquered by the clinical and surgical specialists, but by the ecologists, physiologists and sanitary engineers"

"It was lousy," he replied, "I expected some pearls of wisdom and all I got was advice on how to think of the patient."

I suspect this student had no knowledge of that part of the Bible which says, "Give not that which is holy unto the dogs, neither cast your pearls before swine."

In a recent issue of the *U.S. News and World Report,* there was a significant article regarding the revival of the liberal arts education. I quote " 'The ignorance among present college students in matters of politics, economics, history, science, technology, art and culture is appalling,' asserts Leon Botstein, president

of Bard College in Annandale-on-Hudson, N.Y. Stephen Muller, president of Johns Hopkins University in Baltimore, laments: 'We're turning out highly technical and highly skilled people who are literally barbarians.' 'Employers want people who know how to think effectively, who are articulate and able to reason,' says Philip Jordan, president of Kenyon College in Ohio. He adds: 'It does little good to know a lot about physics, or economics, or medicine if you know nothing about Socrates or Shakespeare or the Norman conquest, because you won't be able to relate your work to society at large or put it in a historical context.' 'It is going to take more than four years to show a student exposed only to "rock 'n' roll" and trash literature that Mozart is better than pop groups and Shakespeare makes more sense than modern pornography,' observes L. Pearce Williams, professor of history and science at Cornell University."

"We (in medical education) may have to follow the lead of big business and choose students for their interest and enthusiasm, rather than their experiences in biology and chemistry or for their high scholastic grades"

So it is with the exercise of clinical judgement that I am most concerned. How can there be good medical judgement when one is incapable of independent judgement in other spheres? In this respect we are at a particular disadvantage, because we are under tremendous pressures towards uncritical conformity and it appears that conform we must. In many instances if we don't conform we don't get paid, and, if we don't conform, we might get sued, and these fears hang heavy over our heads.

Only a few days ago, we heard such words from the Secretary of Health, Education and Welfare, as well as from our President, regarding the proposed rules for limiting many of the services in our hospitals, and we've already had it in the field of medical practice in general. Must we end with Dr. Max Obermyer's prophecy and description of the young physician of twenty years ago? "He (the young physician) is not an interesting person—self-complacent, comfort-loving, and unenterprising, his surly attitude sometimes coupled with colossal ignorances as well as a lack of curiosity about anything not pertaining to the immediate goal, such as passing the American Board of Dermatology, and finally having monetary gain and security. The lack of his knowledge outside his immediate field of interest is exemplified in his hesitancy to express an opinion in a round table discussion with his colleagues."

You may say why belabor this portion of medical education. Well it is because I am all too aware that the scientific and research side of medical education will continue to advance and that the very weight and size of this medical service will take an increasing toll of the years of early manhood to the exclusion of preparation for the physician to live *with* himself and *with* his fellows and prepare him only to work *on* them.

But what about the role of technology in the practice of dermatology? Technology assessment has become a routine exercise for the scientific enterprise on which this country is obliged to spend large sums for its needs. Somehow medicine, for all 80-odd billion dollars it is said to cost the nation, has not yet come in for much of this analytic treatment. It seems to be taken for granted that technology of medicine simply exists, take it or leave it, and the only major technological problem which policy-makers are interested in is how to deliver today's kind of health care with equity to all the people.

In dermatology, the technological process of care of skin diseases has improved enormously and spectacularly since the beginning of the last world war, when there was a great push to improve chemical therapy. As you now must all be aware, we no longer see the severe, extensive and prolonged cutaneous eruptions that occurred in such enormous quantities 40 years ago, such as the extensive cellulitis, pyodermia, carbuncles, severe drug eruptions from arsphenamines with its exfoliative dermatitis, the infectious eczematoid dermatitis, extensive seborrheic dermatitis, the cutaneous syphiloderms that were so extensive and widespread, severe dermatoses from contact eruptions that required many days, and sometimes weeks, of care, the pemphigoid and the pemphigus eruptions that required many weeks, and sometimes months, of hospitalization. All of these conditions have all but disappeared because of better general health. Drugs have definitely assuaged their discomfort, and their course has been effectively shortened by the use of antibiotics and steroids. The dermatologist is a past master with the use of the various creams and ointments that can be applied. He now practices cutaneous medicine with much greater ease and with consummate skill because of his ability to enact quick repair of damage. Thus he is in more and more demand for the care of the smaller things in medicine and can prevent the major ravages of skin disease by using the new bits of medical information brought in from the corners of biologic science.

It has been said that there are three levels of technology in medicine. First of all there is a large body of what may be termed as non-technology. A great deal of time and money is spent on this and it is valued highly by the professionals as well as the patient. It consists of what is sometimes called supportive therapy; it is what is meant by the phrases "caring for" and "standing by." It tides the patients over to the self-limited diseases and provides reassurance. It is indispensable, but it is not, however, technology in any real sense since it does not involve measures directed at the underlying mechanism of disease. The cost of this non-technology is very high and getting higher all the time because it requires not only a great deal of time and effort, but skill on the part of physicians. This is the technology which the dermatologist should use most.

The second level is a kind of technology best termed

as half-way technology. This kind of technology is designed to make up for diseases that are postponed into death. This is represented a great deal by the transplantation of hearts, kidneys, livers, and other organs and of the complex coronary care that takes place. Here the dermatologist had little part to play except in the treatment of cancer by irradiation or chemotherapy.

The third type of technology, the one where the dermatologist is superior, is the kind that is so effective that it seems to attract the least public notice. It has come to be taken for granted. This is the technology in which the specific drug, such as the antibiotics and the hydrocortisones, has cured and relieved so many conditions and the technology which resulted in the defeat of poliomyelitis and smallpox. It comes as a result of genuine understanding of disease mechanism. As available, this technology is relatively inexpensive, relatively simple, and relatively easy to deliver.

If a case of typhoid fever had to be managed today by the best methods of 1935, it would run to a staggering expense, such as fifty days of hospitalization requiring the most demanding kind of nursing care, an excessive concern for details of diet with daily laboratory monitoring, and occasionally, surgical intervention for abdominal catastrophe. The conservative cost of this illness would be estimated at $10,000 as contrasted with today's cost of a bottle of chloramphenicol and a day or two of fever.

I should like to end this dissertation with some quotations from a recent speech by a famous trial lawyer, Edward Bennett Williams, on the "Myth of Equal Results." The first quotation comes from Alexis de Tocqueville of a century and a half ago: "There is indeed a manly and legitimate passion for equality which arouses in all men a desire to be strong and respected. This passion tends to elevate the little man to the rank of the great. But the human heart also nourishes a debased taste for equality, which leads the weak to want to drag the strong down to their level and induces men to prefer equality in servitude to inequality in freedom." The really great people of each generation are those who have a commitment to excellence, a commitment to be all times and all places under all circumstances the very best they can be at whatever they do. John Garner had said it best in this century: "An excellent plumber is infinitely more admirable than an incompetent philosopher. The society which scorns excellence in plumbing because plumbing is a humble activity and tolerates shoddiness in philosophy because it is an exalted activity will have neither good plumbing nor good philosophy. Neither its pipes nor its theories will hold water." And, lastly, he writes, "I think the best kept secret in America today is that real satisfaction, real fulfillment, real exhilaration come not from leisure, or tranquility, pampered idleness, or self-indulgence, but rather from striving with all one's physical and spiritual might for a worthwhile objective."

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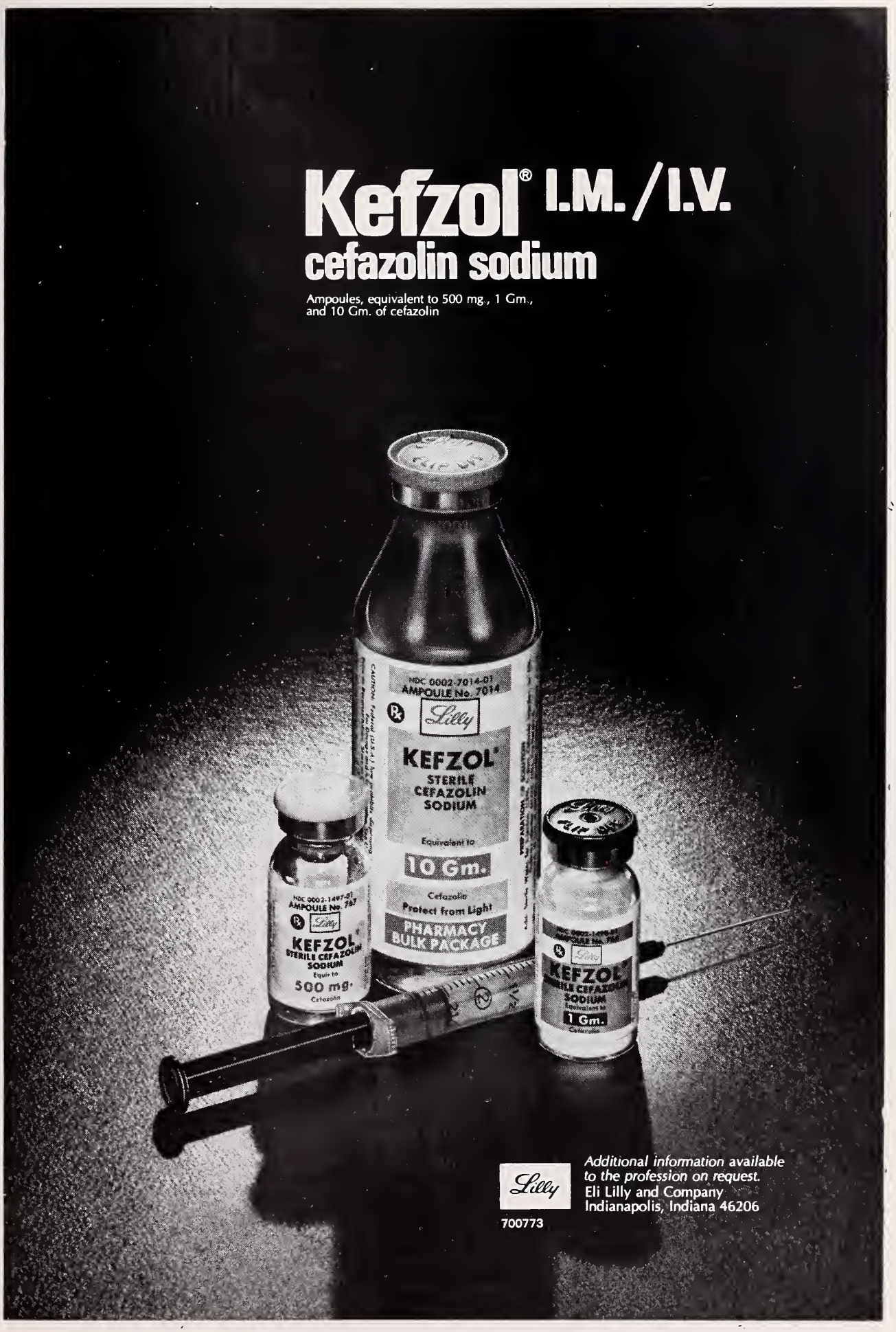
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What Can We Do About Child Abuse?

VIOLENCE AGAINST CHILDREN by their parents or caretakers has been publicized by professionals in medicine, law, social service and others since first described in the "Battered Child Syndrome" in 1962 by C. Henry Kempe, M.D., et al. Laws mandating reporting of cases of suspected abuse and granting immunity from prosecution for this type of reporting have been passed in all 50 states. As a result of increased recognition and reporting, figures now indicate that as many as 1.6 million children are abused and 2,000 die annually from abuse. Abuse is thus second only to Sudden Infant Death Syndrome as a cause of death in infants 1-6 months old and second only to true accidents in children 1-5 years old.

Although many of these children have injuries serious enough to be treated by physicians, nationally only 1.6% of 350,000 cases of abused children reported in 1976 to the National Center for Child Abuse and Neglect came from private physicians. Hospital personnel, nurses and paraprofessionals accounted for another 10%. About 50% are reported by parents, relatives, neighbors and school authorities. The remainder are reported by police, social workers and others.

In Georgia from July 1, 1976 to June 30, 1977, private physicians reported only 3% of 1,451 suspected cases, and hospitals, clinics and public health officials accounted for 16%. It has been suggested that physician reporting is so low because these children are not taken to doctors, but figures indicate that of 1,103 confirmed or undetermined cases *40% had been seen by a doctor,* a discrepancy of over 20% between those seen and those recognized (reported).

What can physicians do to improve their awareness and thus their recognition and management of the problem? Initially, all general surgeons, emergency room physicians, pediatricians, orthopedists, neurosurgeons and others should be sure that they have a complete and accurate medical history on the child, including questioning the child also, privately, if he is old enough to cooperate. This should be correlated with an assessment of the developmental abilities of the child and the types and locations of all noted trauma, old and new.

If the evidence points to suspicion of abuse, it must, by law, be reported to the Protective Services Division or P.S. case worker of the County Department of Family and Children's Services or to the police. If a physician is not sure whether or not he should be suspicious, he should call in a consultant or hospitalize the child for care, thus protecting the child while taking the time necessary for a more thorough evaluation. Many parents will accept hospitalization for observation since it also protects them.

Additionally, physicians should support legislation for increased funding

and staffing of state and county protective services divisions, in order to provide more prompt and comprehensive services to protect the children.

Finally, physicians should be foremost in working for better recognition of potential abusers in their obstetrical patients prior to delivery and in their new parents so that intervention and counseling may stop abuse *before it happens*.

These are but a few of the factors we should stress in dealing with this problem which is affecting many of our children and may directly interfere with their development into responsible stable adults capable of providing good parenting to their own offspring.

Barbara Bruner, M.D.
Associate Professor of Pediatrics
Emory University School of Medicine and
Assistant Director
Grady Pediatric Clinics

The Inequity of Fee Allowances of Third Parties

DELINEATION OF FEES ACCORDING to geographical areas, as practiced under Medicare-Medicaid and certain private contracts following the "usual, customary and responsible" method of reimbursement, is discriminatory—discriminatory toward physicians in rural areas and, more significantly, toward their patients. Determining the fee of a physician solely on the basis of the location of his office seems unwise, unfair, and to the non-legal mind, illegal.

Since physicians with increasing frequency are choosing to contract with their patients for fees, rather than accept assignment, it is the patient who is reimbursed a smaller percentage of his cost if he consults a doctor across a county line in a lower fee area.

There is now a doctor for about every 540 people and still there are too few physicians to provide the necessary primary care in rural areas. Despite the various explanations offered for the maldistribution of physicians, the real reasons most likely are:

1. Disproportionately low fees resulting in low income;
2. Paucity of free time because of lack of colleagues to provide cross-coverage;
3. Additional work in the hospital required of the physician himself, such as technical procedures, paper work and night calls for minor problems, which in larger towns are provided by house staff, emergency room physicians and hospital paid allied professionals;
4. Lack of prestige comparable to the city colleague.

A young graduate must feel an urge with missionary zeal to serve a social need when he chooses a rural practice location under present circumstances. Actually, the fee differential should be reversed and a fee supplement offered for additional services required of the small-town physician.

The "usual, customary, reasonable" concept of fee determination will have to be discarded before fee problems can be corrected nationally. UCR serves to perpetuate inequities between urban and rural physicians and among specialties. Not all of our medical colleagues are paid in proportion to the value of the services rendered as determined by time, skill, experience and patient responsibility.

The MAG House of Delegates in 1977 faced the issue responsibly and

voted to request HEW to redesignate Georgia a single area for reimbursement purposes. This is a constructive step toward correcting a real problem. The procedure required by HEW for the change has proved to be slow and cumbersome and is not yet in effect. However, the details should have been completed in time to be reflected in changes due in July when fees are next scheduled to be upgraded.

The MAG in this action has demonstrated to the small-town physician and his patients that it recognizes the problems and is making an effort to help.

Charles S. Hollis Jr., M.D.
P.O. Box 288
Albany, Ga. 31702

So You Want Better Public Relations

IN THIS AGE of technology and the electronic press, we find ourselves trying to tell the public who we are and what we are and we find ourselves fighting a new tiger. This animal is called public relations or PR. Why is it important? And who should do it?

According to *Webster's,* public relations is "the business of inducing the public to have understanding for and goodwill toward a person, firm or institution."

Why do we need good PR? We, as physicians, are already highly respected—consistently in the top five of those most respected professions—generally first or second. However, as public issues become more complex, serious and numerous, each patient reexamines what he thinks about doctors. It is time, as never before, to become more effective in our public relations efforts.

Before all our rights are legislated away, what can be done? Public relations at MAG is supplying answers to the requests that come in each week from the news media; it's the news releases that are issued statewide on matters of real importance; it's the scheduling of physicians on radio and TV talk shows; it's our new radio show "For Good Health"; it's our efforts at keeping you informed via the *Newsletter, Journal* and special mailings; it's MAG's response to the occasionally biased newspaper article; it's the face-to-face meetings with reporters and other media representatives, and more.

But that is not enough! MAG cannot do it all.

Most importantly, our best PR is you! Each day as you relate to your patients, you are establishing in the public's mind their image of medical practitioners—of doctors. If we truly want the public to have "understanding for and goodwill toward" medicine, then that greater understanding between physicians and the public begins with each of us—at the local level. This, in turn, will propagate greater understanding at the state and national levels where health care legislation is created.

So, the next time you get concerned about how the public feels about medicine in general, about "our" public relations efforts, ask yourself, "How do my patients feel about me?" They probably feel much the same about doctors and medicine as they feel about the caliber of care you offer them and the interest you show in them in the solving of their problems. Let's put our best foot forward!

Marvyn D. Cohen
Chairman, MAG Communications Committee

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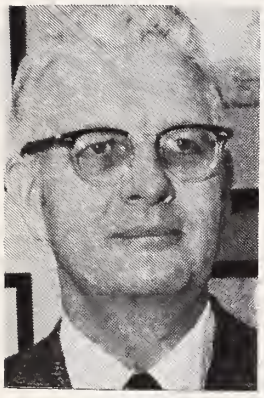
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president's letter



JOHNSON

Drowned in Alphabet Soup

THE RING TIGHTENS, the federal grip becomes stronger on physicians and their patients. Even though socialized medicine, under the pseudonym of "National Health Insurance" is not a reality, the socialist bureaucrats that control the federal government are busy chopping away at private medical care by the so-called salami technique.

I remember the story about the two fellows who were fighting with straight-edged razors. One took a swipe at the other's neck with his sharp blade after which the other shouted, "Aha, you missed me!"

To which the other replied, "Boy, just wait until you try to turn your head!!"

We are near this point now.

The federal government, in collusion with some of our own numbers, is engaged in a grand play to divide, decimate and destroy the medical profession's resistance to the destruction of private quality medical care in this country.

First they set up Medicare and then Medicaid, and when the cost over-runs were apparent, they began to cut services and fees.

By what system of ethics do these people discriminate against physicians, when they all draw 100% of their 1978 salaries and pay you 75% of 90% of what they have decided you should have charged for your services in 1975?

Next they sent us PSRO, which is so bad a law that even the bureaucrats are mumbling to get rid of it as not "cost effective." Their propaganda to pass the bill claimed that it would insure "quality." This concept seems now to be lost and the true reason for this odious concept has come to light.

As if this weren't enough, they funded programs to "train" physicians' assistants with two years of college to do the work of primary care physicians. As predicted, the true reason for this was not to assist physicians but to set up cheap medical services. Rural physicians will soon find themselves in competition with medical offices staffed by these superficially trained people all paid for by a private foundation and out of our taxes and without direct medical supervision. City physicians may soon see the state go into the practice of medicine in the county health department offices, charging fees for services rendered by poorly trained para-medical personnel using protocol books.

Next comes "certificate of need" legislation whereby a person cannot invest his capital because competition *raises* prices!! This is a strange paradox, because the federal government under the Hill-Burton Act built most of the "excess" hospital

beds. It now appears that even the Constitution of the State of Georgia is to be sacrificed to obtain federal money.

Now comes regionalization of health care under which, according to present regulations, quality medical care will be driven from the rural areas because physicians will not work where there are no facilities to practice their skills.

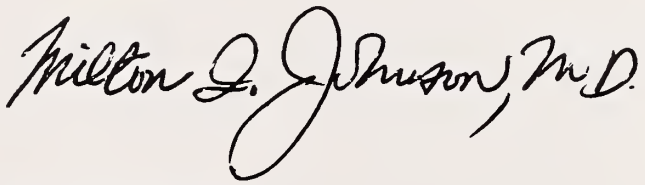
The grandest affront is the HSA law, sure to become the worst transgressor against liberty devised in a long time.

We must each ask ourselves, "how long will we continue to cooperate in our own demise?" Both we and our patients are sure to drown in the alphabet soup of Medicaid, Medicare, PSRO, PA, HSA and whatever else can be dreamt up by the bureaucrats.

To quote President Carter's recent speech, "Government cannot solve our problems. It cannot set our goals. Government cannot eliminate poverty or provide a bountiful economy, or save our cities, or cure illiteracy or provide energy . . . We simply cannot be the managers of everything and everybody."

But they are willing to strangle us to death trying.

Sincerely,



Milton I. Johnson, M.D.
President, Medical Association of Georgia

CHECK YOUR ROSTER LISTING

Compilation of the 1978-79 *Roster of the Medical Association of Georgia* is now underway. We want it to be as accurate as possible, and we need your help.

After May 1, 1978, no additions, deletions or corrections can be made.

Please check your listing in the *1977-78 Roster* and make sure it is as you want it to appear in the new *Roster*. Check spelling, address, specialty and status. If any changes are needed, please put them *in writing* and send them to: Karyn Donehoo, Membership Records Administrator, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta, Ga. 30309.

Thank You!

Deadline: May 1, 1978

I've told this before . . .

(Editor's note: Could a piece of string be a reminder to birds as well as to us humans? Dr. McDaniel explores that possibility in his story this month. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Bird Nests

I HAVE OFTEN wondered how and when birds choose a place to build their nests. Several springs ago, I noted some activity by a pair of robins that may give a little clue.

Our home has three stories in the back and we sleep on a sleeping porch that faces the east. On that side we are well up in the pine trees that flourish there—many near the house.

When daylight comes, I wake up when the birds first begin to chirp. On this particular morning I noticed a mother robin doing some peculiar gyrations out near the end of a branch that had several forks. It was sort of a dance: she jumped up and down on smaller limbs, then on the main part, turned around and around, and actually shimmied. I watched all this with some wonderment. Later after dressing, I walked back on the sleeping porch to see if my friend was still dancing. No, she wasn't, but there was a white piece of string about 6-8 inches long draped over the limb.

For some ten days, the first thing I looked at near sunrise was that string. Then one morning I saw both mother and father dancing on the limbs, fluffing their feathers and turning around and around. The next morning a nest was halfway built; the following morning it was completed. And several days later mother robin was sitting on the nest.

The dance is understandable. They were testing the strength of the limbs as they built the nest. I saw them belly down while building their nest and go around and around making it conform to their bodies—but the white string and the interval of 10-14 days puzzles me. I could not find other white strings.

Could it be that birds test several likely spots and mark them some way days in advance, then finally choose one?

J. G. McDaniel, M.D.
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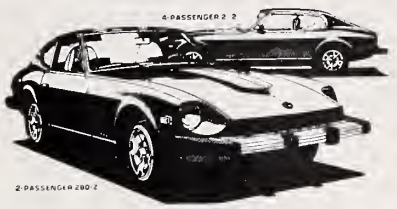
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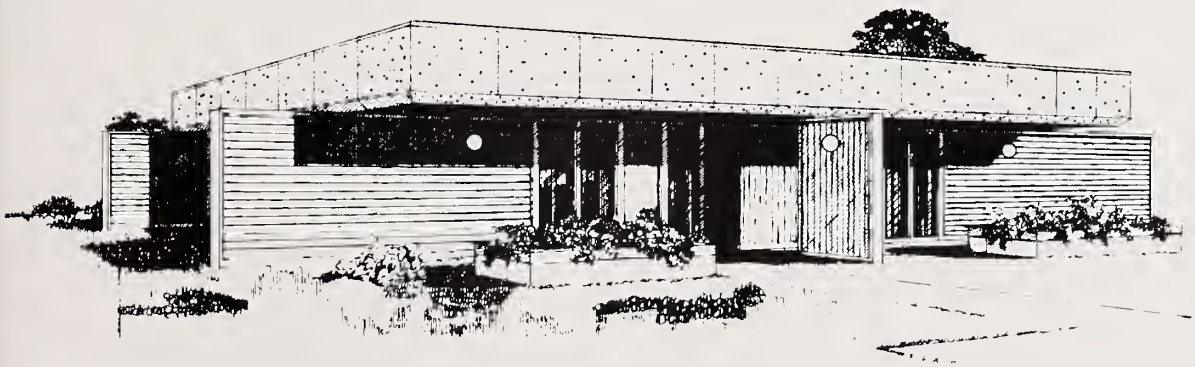
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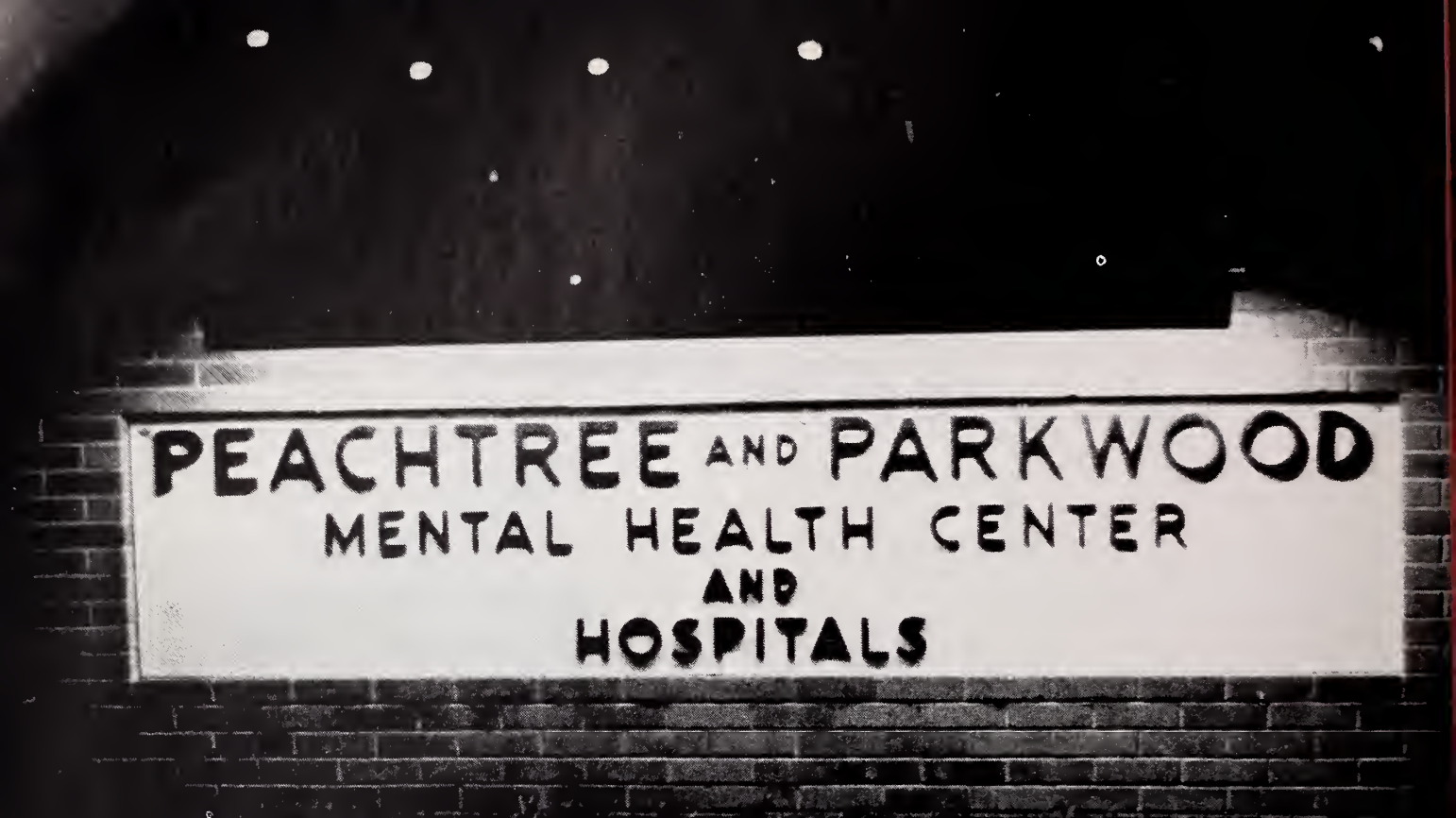
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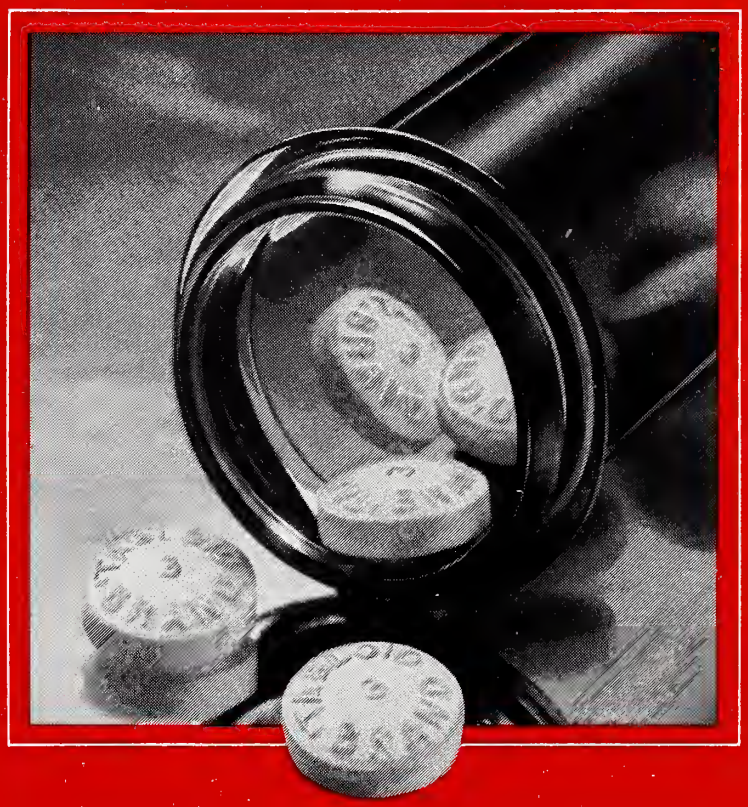
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Kaon Tablets/Kaon Elixir

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Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

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Overdosage: See Kaon Tablets.

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* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Child Abuse in Georgia: the Doctor's Legal Responsibility

ROBERT N. BERG, *Atlanta**

YOU ARE TREATING A CHILD under the age of 18 and you suspect that the child's injuries were not accidental and may have been caused by the child's parent or caretaker. The injuries could be of a physical nature, the result of the child being beaten, burned, poisoned, sexually assaulted or otherwise physically abused; alternatively, the injuries could indicate that the child has been neglected by his or her parent or caretaker. In either case, you suspect that the child may be one of the 60,000 children who are the victims of child abuse and child neglect each year.[1] You treat the child's injuries and send him home; have you met all of the responsibilities placed on you by law?

If you are a physician, including any doctor of medicine licensed by the State of Georgia, a licensed osteopathic physician, intern, resident, dentist, psychologist, podiatrist or public health nurse (or non-physician personnel, such as a social worker, teacher, school administrator, child care personnel, day care personnel or law enforcement personnel), the answer is *no*.

The Duty to Report Incidents of Child Abuse and Child Neglect

Section 74-111 of the Georgia Code, as amended (the "statute"),[2] provides that physicians, treating personnel, institutions and others, as listed above, having cause to believe that a child under the age of 18 has had physical injuries inflicted upon him other than by accidental means, or has been neglected or exploited, or has been sexually assaulted by a parent or caretaker, have a duty to report such an incident to an appropriate agency.[3] Moreover, the failure to make such a report is punishable as a misdemeanor.[4]

The duty to report is triggered when the physicians or other personnel named above "have cause to believe" that a child has been abused or neglected; in that context, the statute does not define the phrase "cause to believe." It should be noted, however, that it is not necessary that a physician have definite knowledge

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, Georgia 30303.

that abuse or neglect is present; there need only be a "belief" or "suspicion"[5] that such a condition exists.

The Nature and Content of the Report

Pursuant to the statute, "an oral report shall be made immediately, by telephone or otherwise,"[6] to a child welfare agency providing protective services and to an appropriate police authority; a subsequent written report may be necessary if such a report is requested by the agency or by the police. If, however, the person suspecting child abuse or neglect is a member of the staff of a hospital, school, school agency or similar facility, he is required to notify the person in charge of the facility, and the statute places the duty to report on the person in charge.

The report must contain the names and addresses of the child and his parents or caretakers, the child's age and the nature and extent of the child's injuries. Additionally, the person making the report may supply any other information which might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

Immunity From Liability and Confidentiality of Records

The statute provides that any person, association, hospital or other entity participating in the making of a report or causing a report to be made is immune from any liability, either civil or criminal.[7] This immunity also extends to persons participating in judicial or other proceedings resulting from the making of a report.

Additionally, records in the custody of the Department of Human Resources or other state or local agencies concerning reports of child abuse or neglect are confidential and access to these records is prohibited,[8] unless access is legally mandated by a child protective agency or by court or grand jury subpoena.[9] However, access may be granted to a physician who has before him a child whom he reasonably suspects may be abused or neglected.[10]

Conclusion

In total, the legal obligation placed on physicians, hospitals and other personnel goes beyond the treatment of children who are the victims of child abuse and neglect, and extends to the prevention of future abuses and neglect. By requiring the mandatory reporting of cases of child abuse and child neglect, the statute ensures that the protective services provided by the state will be utilized in an effort to prevent further abuses, and that the welfare of these children will be protected and enhanced.[11] Moreover, by requiring the reporting of instances of child abuse and neglect and by providing for the confidentiality of such reports and immunity from civil and criminal liability for those persons or institutions required by law to make these reports, the statute satisfies the requirements of the federal "Child Abuse Prevention and Treatment Act"[12] and enables the state to receive federal financial assistance to develop, strengthen and carry out its program of child abuse prevention and treatment.

Notes

1. Report of the House Committee on Education and Labor, No. 93-685, November 30, 1973.
2. Acts 1977, pp. 242-244.
3. Ga. Code Ann. §74-111(a).
4. Ga. Code Ann. §74-111(d).
5. Op. Atty. Gen. 76-131 (December 22, 1976) provides that the phrase "cause to believe" is equivalent to the phrase "cause to suspect."
6. Ga. Code Ann. §74-111(b).
7. Ga. Code Ann. §74-111(c).
8. Ga. Code Ann. §99-4301.
9. Ga. Code Ann. §99-4302(a)(1), (2), (3).
10. Ga. Code Ann. §99-4302(b)(1).
11. Ga. Code Ann. §74-111(e).
12. 67 U.S.C.A. §5101 et seq.

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PERSONALS

First District

Edgar J. Filson, M.D., has been installed as chief of staff for Candler Medical and Dental Hospital. **John M. Fillingim, M.D.,** of Savannah, was named chief of staff-elect.

Third District

Columbus physician **Howard G. Vigrass, M.D.,** has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Fifth District

A. Hamblin Letton, M.D., of Atlanta, secretary-director of the Southeastern Surgical Congress, helped stage its 46th annual assembly held in New Orleans in February. **Fred Allman, M.D.,** of Atlanta, discussed "Lower Extremity Injuries in Athletes" on the nurses' program. Other Atlantans on the program for the assembly included **Paul E. Stanton, M.D., Douglass G. Whitney, M.D.,** and **H. Harlan Stone, M.D.**

Atlanta physician **Kenneth B. Alonso, M.D.,** has been appointed the new chairman of the medical staff at Physicians and Surgeons Community Hospital.

Milton F. Bryant, M.D., of Atlanta, has been elected to the Board of Governors of the Medical Center Alumni Society from the University of Michigan.

David Dennison, M.D., of Atlanta, has been installed as chief of staff for West Paces Ferry Hospital.

Georgia Baptist Medical Center Chief of Staff **Edwin C. Evans, M.D.,** is one of 27 U.S. physicians elected for a five-year term to the Institute of Medicine of the National Academy of Sciences. Dr. Evans was also elected as vice-chairman of the executive council of the Southern Medical Association.

Atlanta physician **I. Lehman Lindsey, M.D.,** was guest speaker in January at the Chattahoochee Council of the Georgia Association for Children with Learning Disabilities. Dr. Lindsey discussed the theories of causes and types of hyperactivity in children.

Charles F. Nicol, M.D., of Atlanta, has been named a fellow in the American Academy of Neurology.

Somphong Thitaram, M.D., of Atlanta, is the new vice-chairman of medical staff at Physicians and Surgeons Community Hospital in Atlanta.

Sixth District

H. Calvin Jackson, M.D., of Manchester, has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

R. O. Schoffstall, M.D., of Macon, participated in the program at the 46th annual assembly of the Southeastern Surgical Congress held in New Orleans in February.

Seventh District

Douglasville physician **J. Gordon Barrow, M.D.,** has been named chief of staff at Douglas General Hospital.

Lee Battle, M.D., of Rome, has been elected vice-chairman of the Shorter College Board of Trustees.

Kennesaw physician **Stephen C. May, M.D.,** has been named vice-chairman of the Joint Advisory Board of Family Practice for 1978.

Robert W. Simmons, M.D., of Dalton, has been ap-

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Eighth District

Valdosta physician **J. H. Brannen, M.D.,** has been elected president of the Georgia Urological Society.

Tenth District

Talmadge A. Bowden Jr., M.D., of Augusta, participated in the program at the 46th annual assembly of the Southeastern Surgical Congress held in New Orleans in February.

DEATHS

S. Ross Brown

S. Ross Brown, M.D., of Griffin, died January 21 at the age of 79. Dr. Brown, a graduate of Emory University, was a member of the Fulton County Medical Society, the American Society of Anesthesiologists, and a former staff member of Georgia Baptist Hospital.

Surviving are his wife, Mrs. Florie J. Brown, a sister, and seven nieces and nephews.

Robert E. Perry Jr.

Robert E. Perry Jr., M.D., president of the Medical Association of Georgia since last April, died December 30 at the age of 56. A native of Sylvania who was currently residing in St. Simons Island, Dr. Perry was a pathologist at Glynn-Brunswick Memorial Hospital and was a former member of the Brunswick City Commission.

Surviving are his wife, Mrs. Alice Carol Dodson Perry, a son, two daughters, a stepson, a stepdaughter and four grandchildren.

Oliver C. Pittman

Commerce physician Oliver C. Pittman, M.D., 68, died January 10. Dr. Pittman was past president of the Commerce Lions Club and a 1935 graduate of Emory Medical School.

Surviving are his wife, Mrs. Frances Adair Pittman, a son, two daughters, a sister and eight grandchildren.

Second Management Workshop Scheduled

Due to the excellent response to our January Practice Management Workshop for resident physicians, the MAG has arranged to hold a second workshop, "How to Establish a Successful Practice." Co-sponsored by Practice Productivity Inc., the workshop will be held March 28-29, 1978, at the Atlanta Townehouse Motor Inn. The workshop is designed to aid physicians in residency training who are preparing to open up their own practices. Topics to be discussed include employee management and training, physical facility planning, medical records management, appointment scheduling, financial systems, collections, and professional and personal goals. Those interested are advised to register soon to be assured of a place in the workshop. Contact Sue McAvoy at the MAG office in Atlanta (404-876-7535).



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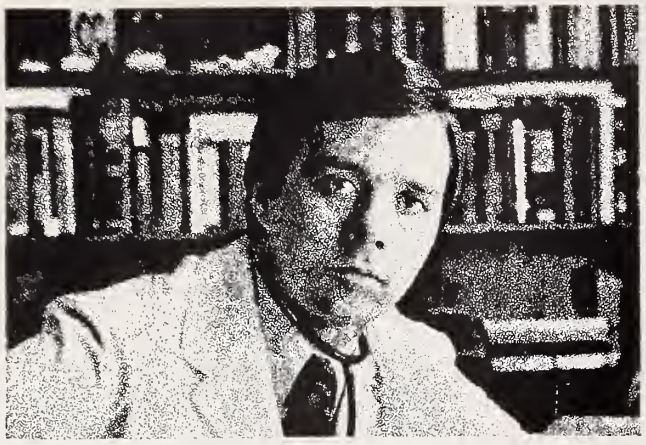
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BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

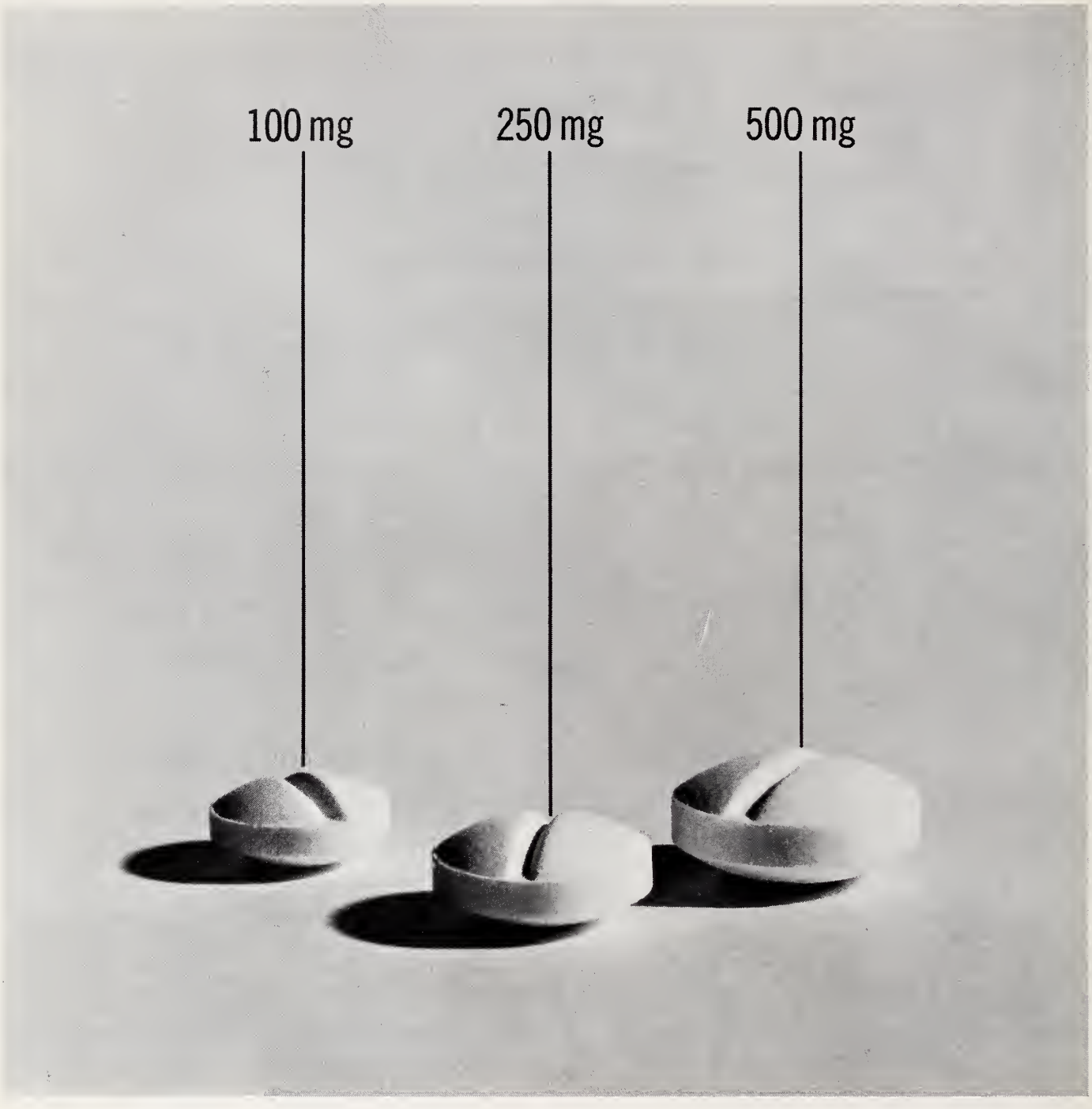
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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Please see brief summary of prescribing information on facing page.
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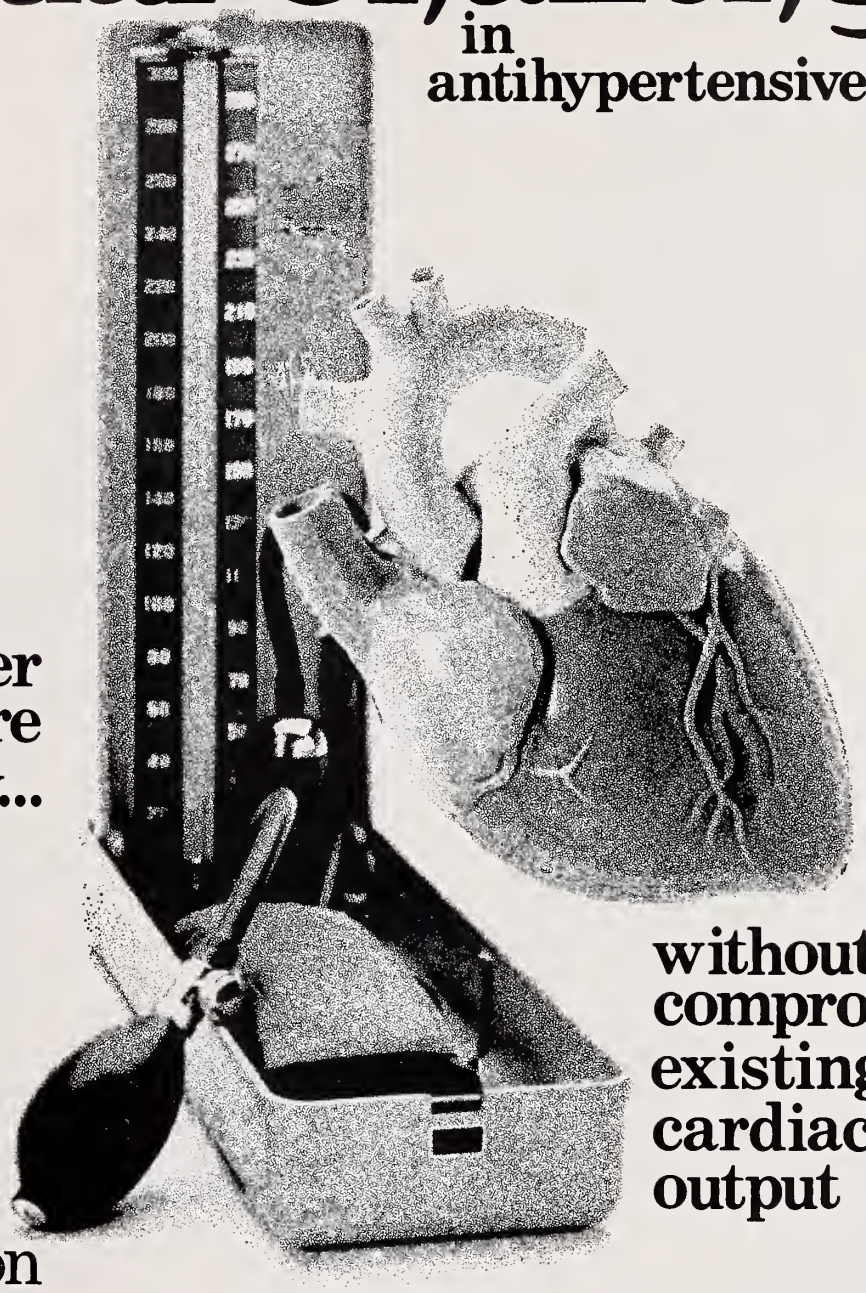
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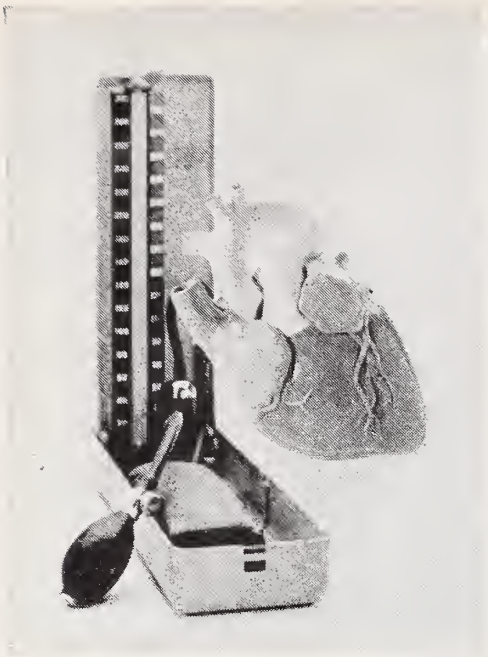
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y occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders
ild lead to potentially fatal complications unless properly recognized and managed. For more
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helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced dos anesthetics; hypotension occurring during anes usually can be controlled with vasopressors. H tension has recurred after dialysis in patien methyldopa because the drug is removed by procedure.

Adverse Reactions: *Central nervous system:* tion, headache, asthenia or weakness, usually and transient; dizziness, lightheadedness, sym of cerebrovascular insufficiency, paresthesias, p sonism, Bell's palsy, decreased mental acuity, in tary choreoathetotic movements; psychic c bances, including nightmares and reversible psychoses or depression.

Cardiovascular: Bradycardia, aggravation of a pectoris. Orthostatic hypotension (decrease dosage). Edema (and weight gain) usually relie use of a diuretic. (Discontinue methyldopa if e progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention stipation, flatus, diarrhea, mild dryness of mouth or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice disorders.

Hematologic: Positive Coombs test, hemolytic an Leukopenia, granulocytopenia, thrombocyto Positive tests for antinuclear antibody, LE cell rheumatoid factor.

Allergic: Drug-related fever, lupus-like sync myocarditis.

Other: Nasal stuffiness, rise in BUN, breast en ment, gynecomastia, lactation, impotence, decr libido, dermatologic reactions including eczem lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 5 daily when given with antihypertensives othe thiazides. Tolerance may occur, usually betwee ond and third months of therapy; increased dos adding a diuretic frequently restores effective c Patients with impaired renal function may resp smaller doses. Syncope in older patients may lated to increased sensitivity and advance teriosclerotic vascular disease; this may be a by lower doses.

How Supplied: Tablets, containing 1 methyldopa each, in bottles of 100; Tablets, cont 250 mg methyldopa each, in single-unit packa 100 and bottles of 100 and 1000; Tablets, cont 500 mg methyldopa each, in single-unit packa 100 and bottles of 100 and 500.

For more detailed information, consult your representative or see full prescribing infor

Merck Sharp & Dohme, Division of Merck & Co West Point, Pa. 19486 J6AMO

MSD MERCK SHARP & DOHME

Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

C/RD PD-JA-1699-2-P (8-76)

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Detroit, Michigan 48232

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SUNBELT COMMUNITY EMERGENCY PHYSICIAN—La Grange, only 60 miles southwest of Atlanta. Immediate opening for experienced emergency department staff physician in beautiful southwest Georgia setting. Fantastic recreational area! $45,000 plus benefits. Send curriculum vitae to Warren Ingalls, M.D., Director of Emergency Services, West Georgia Medical Center, 1514 Vernon Road, Box 1169, LaGrange, Georgia 30240, or call toll free 1-800-325-3982, Ext. 220.

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STAFF:

BOAZ HARRIS, M.D., Medical Director
CONWAY HUNTER, JR., M.D., Director, Addictive Disease Unit
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JOHN B. HARDMAN, M.D., Director, Children's Unit

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hat's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is separately accredited by the Joint Commission on the Accreditation of Hospitals.

plete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200



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JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

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STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

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can effectively relieve anxiety and its somatic symptoms.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

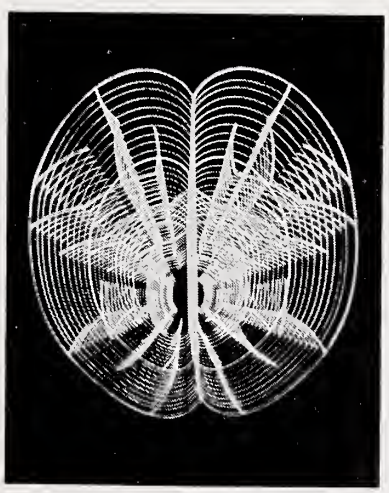
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

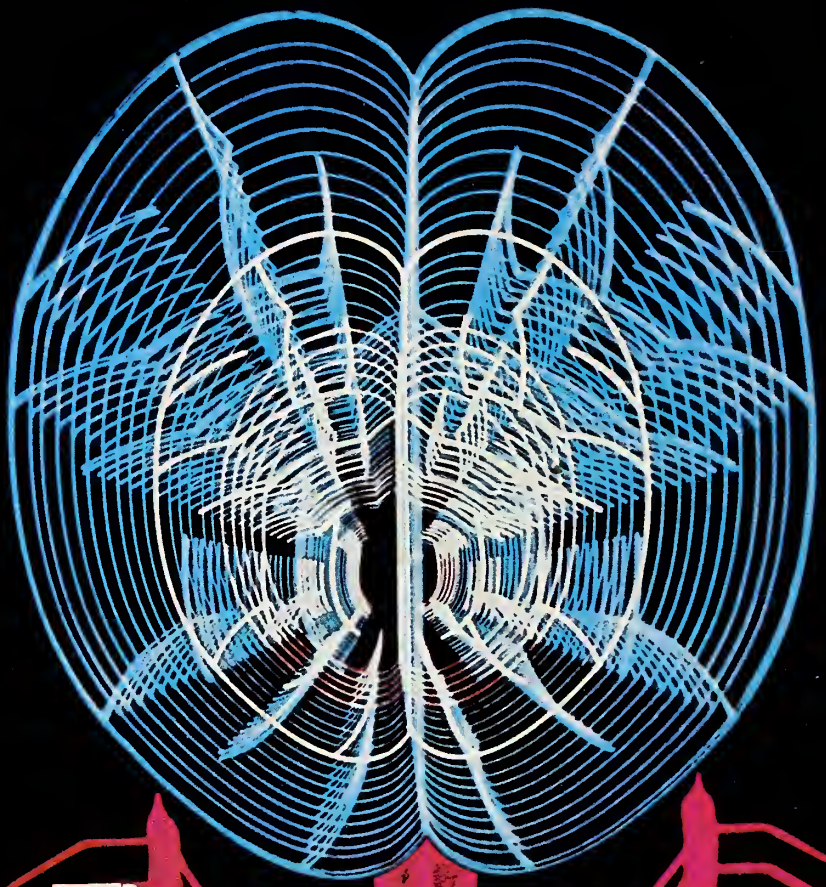
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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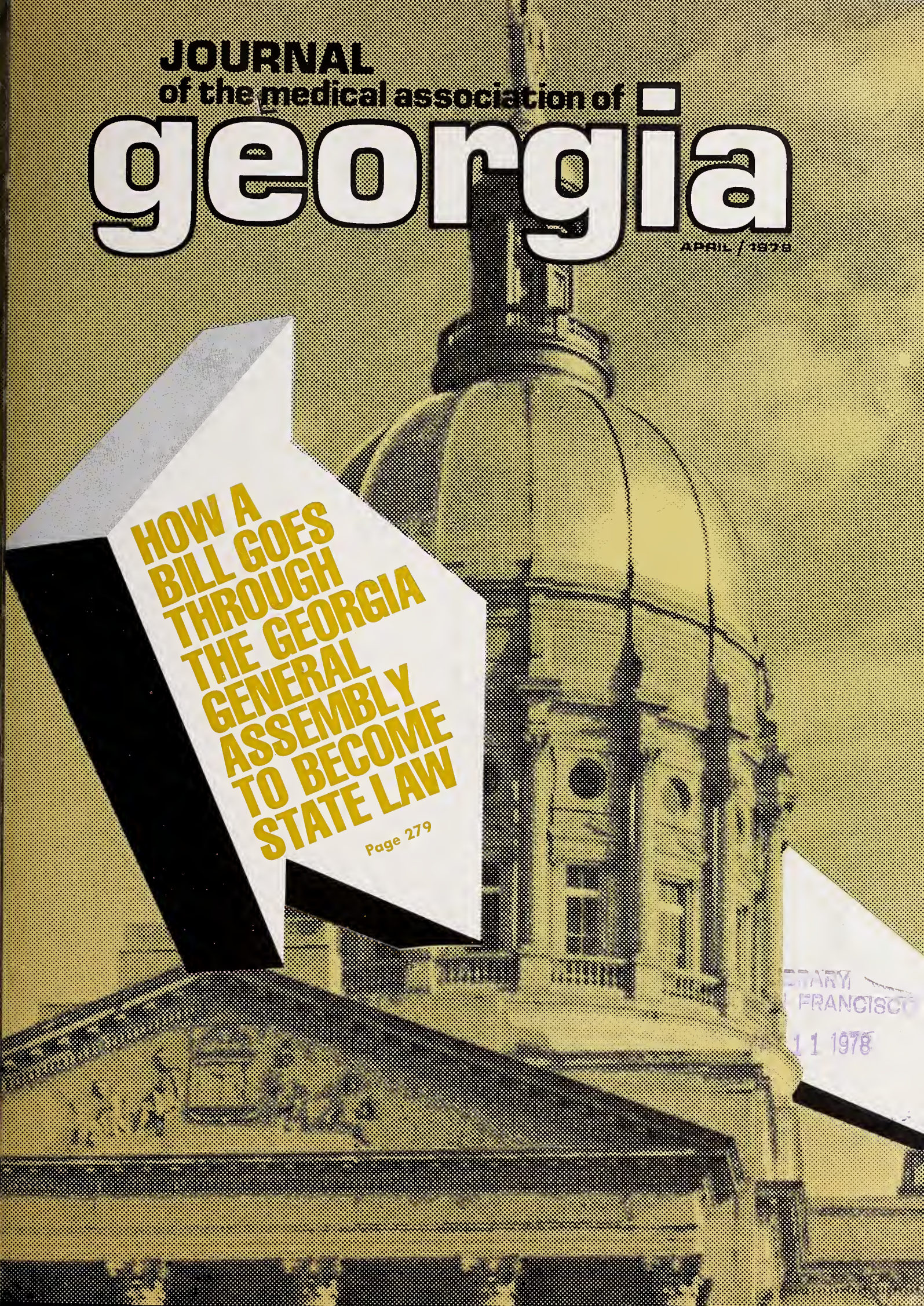
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Please see the preceding page for a summary of product information.

Artist's symbolic conception of a CNS reaction to excessive stress in the overanxious patient, resulting in somatic symptoms of the gastrointestinal and cardiovascular systems. Special photographic lighting techniques were applied to a model of the brain

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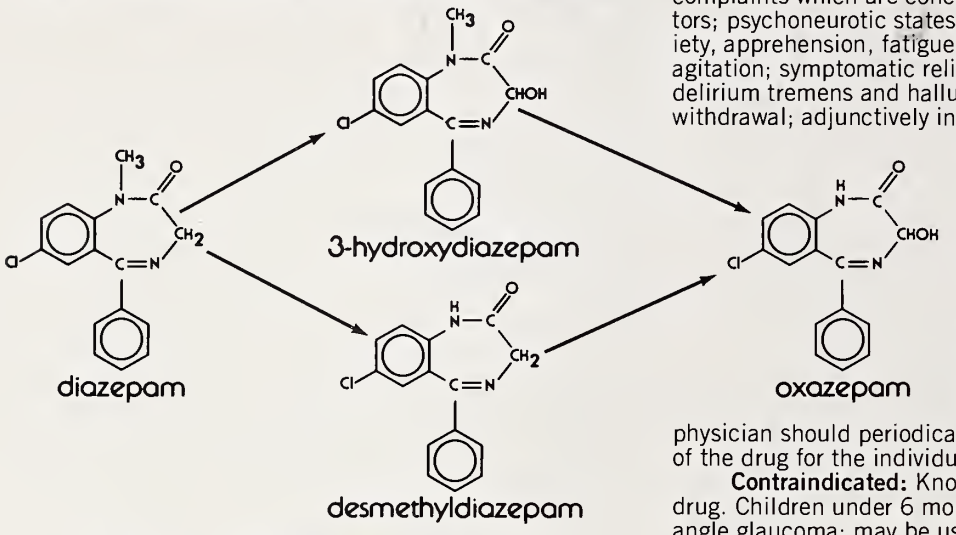


HOW A BILL GOES THROUGH THE GEORGIA GENERAL ASSEMBLY TO BECOME STATE LAW

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FRANCISCO
1 1 1978

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

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Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Brawner Hospital, Inc.

Established in 1910
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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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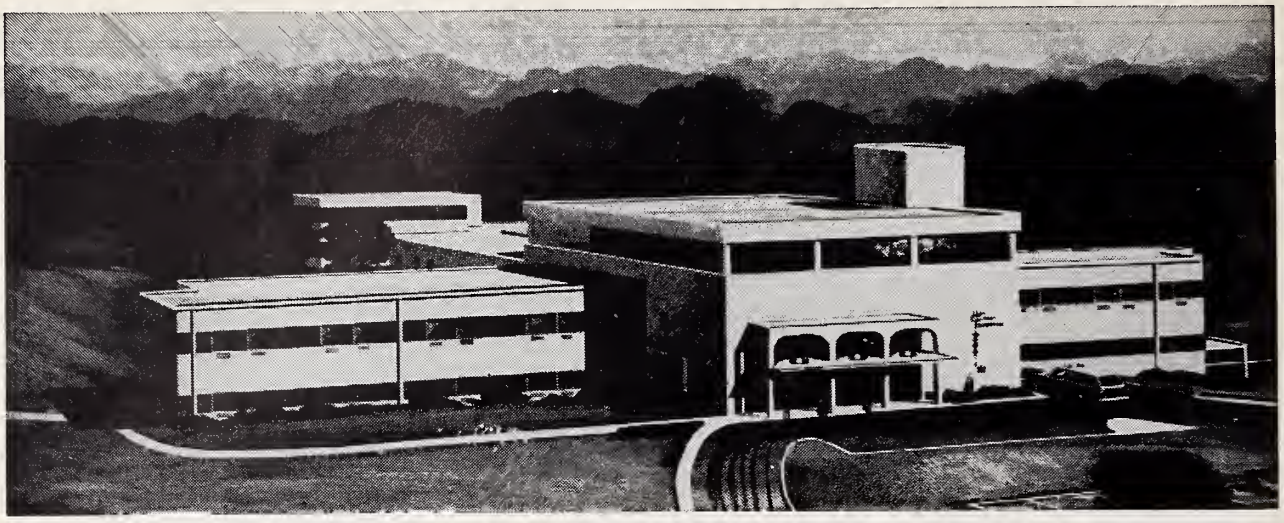
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THE COVER

The bill has to go through quite a lot to become a Georgia law. The steps are listed on page 279. Rusty Kidd, MAG's Director of Legislative Activities, traces the fascinating history of this year's medical communications bill, beginning on page 275. The following other legislative topics are discussed in this issue: actions of the Georgia Psychiatric Association, page 300; the history of Florida's medical examiners system, page 282; Georgia's medical examiners system, page 299; the Joint Board of Family Practice, page 301; the defeat of this year's right to die law, page 311; the experiences of one Doctor of the Day at the General Assembly, page 280; national legislation, pages 273 and 302.



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HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

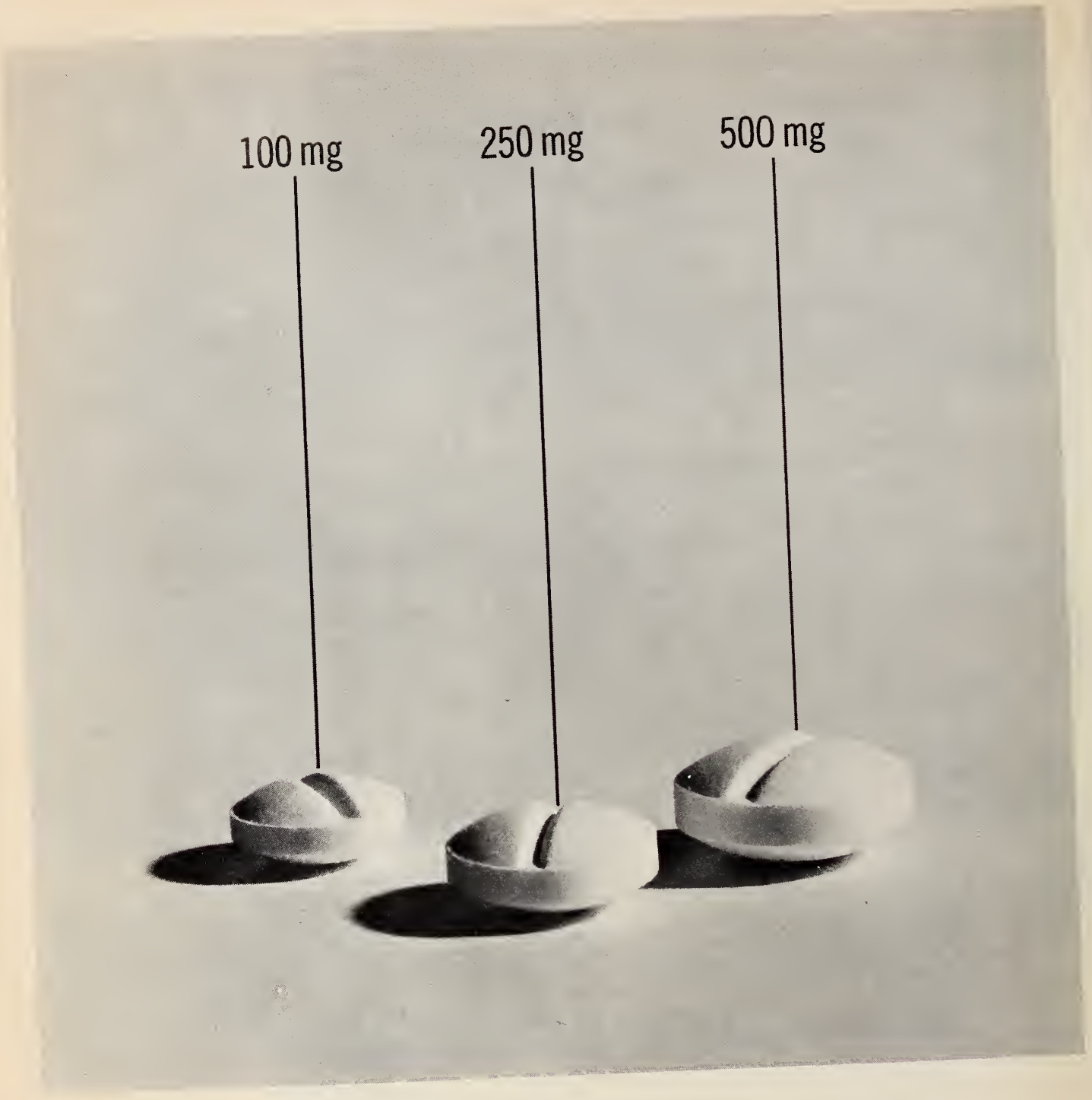
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

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Upjohn

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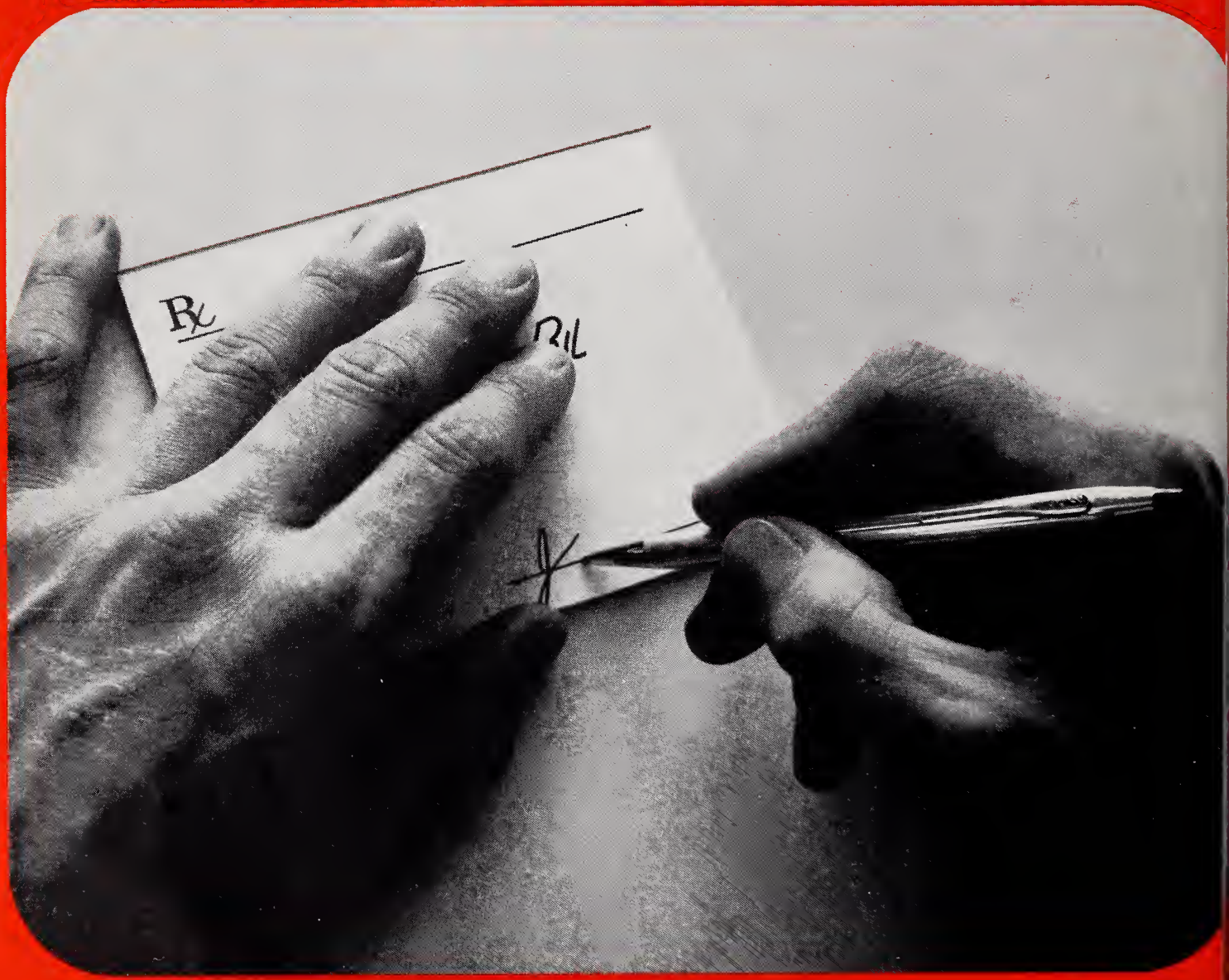
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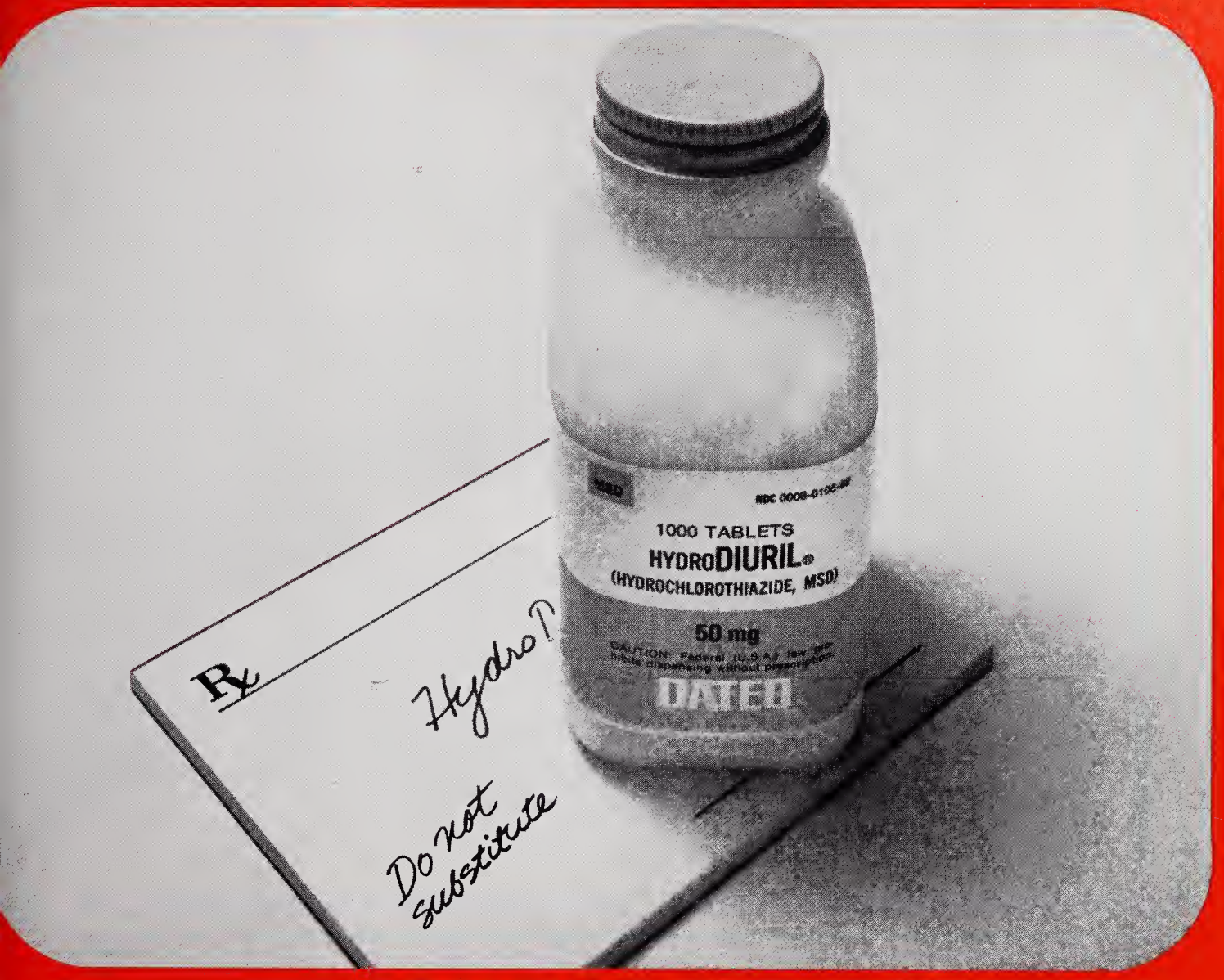
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

airment becomes evident, consider withholding or discontinuing uretic therapy. Thiazides may decrease serum PBI levels without gns of thyroid disturbance. Calcium excretion is decreased by iiazides. Pathologic changes in the parathyroid gland with hyper- alcemia and hypophosphatemia have been observed in a few patients n prolonged therapy; thiazides should be discontinued before testing r parathyroid function.

dverse Reactions: *Gastrointestinal System*—Anorexia; gastric ir- ation; nausea; vomiting; cramping; diarrhea; constipation; jaundice ntrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

entral Nervous System—Dizziness; vertigo; paresthesias; headache; anthopsia.

ematologic—Leukopenia; agranulocytosis; thrombocytopenia; plastic anemia.

ardiovascular—Orthostatic hypotension (may be aggravated by cohol, barbiturates, or narcotics).

ypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing ngiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress cluding pneumonitis; anaphylactic reactions.

ther—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; eakness; restlessness; transient blurred vision.

henever adverse reactions are moderate or severe, thiazide dosage ould be reduced or therapy withdrawn.

ote: When used with other antihypertensive drugs, careful observa- ons for changes in blood pressure must be made, especially during itial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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MEDICAL MEETING CALENDAR

MAY

1-6—*Atlanta;* **DIAGNOSIS AND TREATMENT OF LOCOMOTOR DISORDERS II;** Category 1 Credit; Contact: Department of Rehabilitation Medicine, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

2—*Fort Oglethorpe;* **ORTHOPEDICS AND PATHOLOGY;** Category 1 Credit; Contact: Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe 30741.

2, 9, 16, 23, 30—*Atlanta;* **GROUP AND FAMILY THERAPY;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., N.E., Atlanta 30326.

4-6—*Chattanooga, TN;* **BASIC CARDIOLOGY: ECGs AND THERAPY;** Category 1 Credit; Contact: University of Tennessee College of Medicine, Clinical Education Center, Suite 400, 921 East Third St., Chattanooga, TN 37403.

4-6—*Atlanta;* **PAIN: WHAT'S NEW?;** Category 1 Credit; Contact: Department of Rehabilitation Medicine, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-4874.

4-6—*Atlanta;* **SYMPOSIUM ON CONGENITAL HAND DEFORMITIES;** Category 1 Credit; Contact: Robert M. McFarlane, M.D., President, American Society for Surgery of the Hand, 3 Parker Pl., Suite 223, 2600 South Parker Rd., Aurora, CO 80232. PH: 303/755-4588.

5—*Tuskegee, AL;* **F. BERNARD SCHULTZ CARDIOVASCULAR SYMPOSIUM;** Contact: V. A. Hospital, Tuskegee, AL 36083.

5-6—*Point Clear, AL;* **ALABAMA REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Thomas N. James, M.D., F.A.C.P., Department of Medicine, University of Alabama Medical Center, Birmingham, AL 35294.

8-10—*Atlanta;* **CARDIOVASCULAR PHYSIOLOGY FOR PRACTICING PHYSICIANS;** Category 1 Credit; Contact: J. Willis Hurst, M.D., Emory University School of Medicine, Atlanta 30322.

8-12—*Atlanta;* **131ST AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING: SELECTED PORTIONS & COURSES;** Category 1 Credit; Contact: American Psychiatric Association, 1700 18th St., Washington, DC 20009.

11-12—*Atlanta;* **CURRENT CONCEPTS IN ELECTRODIAGNOSIS II;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Emory University School of Medicine, Atlanta 30322.

15-17—*Pine Mountain;* **BASIC CLINICAL NEUROLOGY AND THE NEUROLOGY OF REHABILITATION;** Category 1 Credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

20—*Atlanta;* **RECOGNITION, PREVENTION, AND IMMEDIATE MANAGEMENT OF ATHLETIC INJURIES;** Category 1 Credit; Contact: Division of Orthopaedic Surgery and Department of Rehabilitation Medicine, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-5535.

20-21—*Rougemont, NC;* **PEDIATRIC RESPIRATORY DISEASE SEMINAR;** Contact: Duke University Medical Center, Hospital Dr., Durham, NC 27710.

22-23—*Atlanta;* **CLINICAL ASPECTS OF FAMILY PLANNING FOR PHYSICIANS;** Category 1 Credit; Contact: Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303.

22-26—*Gainesville, FL;* **7TH FAMILY PRACTICE REVIEW;** Contact: Bill Rockwood, Division of Continuing Medical Education, University of Florida, Box J-233, J. H. Miller Health Center, Gainesville, FL 32610.

24-25—*Nashville, TN;* **17TH ANNUAL SEMINAR IN PSYCHIATRY (FOR NONPSYCHIATRISTS);** Category 1 Credit; Contact: Vanderbilt University School of Medicine, Division of Continuing Medical Education, 305 Medical Arts Building, Nashville, TN 37212.

24-26—*Nashville, TN;* **INTERNAL MEDICINE 1978;** Category 1 Credit; Contact: Meharry Medical College, 1005 18th Ave. North, Nashville, TN 37208.

25-27—*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30322.

26-27—*Atlanta;* **1978 AMERICAN SOCIETY FOR PARENTERAL AND ENTERAL NUTRITION SOUTHEASTERN REGIONAL SEMINAR: FUNDAMENTAL PRINCIPLES AND APPLICATION OF NUTRITIONAL SUPPORT—A TEAM CONCEPT;** Category 1 Credit; Contact: James S. Maughon, M.D., Director, Graduate and Continuing Medical Education, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, ext. 2346.

JUNE

2-3—*Atlanta;* **ADVANCED ANATOMY, KINESIOLOGY, AND BIOMECHANICS OF THE HAND AS APPLIED TO CLINICAL PRACTICE;** Category 1 Credit; Contact: Division of Orthopaedic Surgery, Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

4-8—*Atlanta;* **AMERICAN ASSOCIATION OF IMMUNOLOGISTS;** Contact: H. Metzger, 9605 Rockville Pike, Bethesda, MD 20014.

8-9—*Atlanta;* **SECOND ANNUAL CONFERENCE ON PAIN: CHRONIC PAIN, DISABILITY, AND DRUG ABUSE;** Category 1 Credit; Contact: Steven F. Brena, M.D., Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

14-17—*Sea Island;* **THIRD ANNUAL SYMPOSIUM ON LUNG DISEASE;** Category 1 Credit; Contact: Gilbert D. Grossman, M.D., Emory University School of Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

15-17—*Jekyll Island;* **INTERNAL MEDICINE;** Category 1 Credit; Contact: Gerald T. Chambers, M.D., Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

19-20—*Atlanta;* **WHAT'S HAPPENING: NATIONAL CONFERENCE FOR TEENAGERS ON SEX, BIRTH CONTROL, TEENAGE PREGNANCY, AND OTHER HEALTH PROBLEMS OF TEENAGERS;** Contact: Family Planning Program, 69 Butler St., S.E., Atlanta 30303.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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National Legislative Update

Legislation, currently pending before Congress, of primary interest to MAG

H.R. 10460: S. 2410 HEALTH PLANNING AMENDMENTS

Both bills amend the Health Planning Law (PL 93-641) to do the following:

A) Extension of Certificate of Need (CON) to physicians' offices. State CON laws would be extended to cover the purchase of major medical equipment in any setting, including the physician's own office.

MAG opposes the extension of CON to physicians' offices. There is no evidence to indicate CON for institutions has been successful, and further extension at this time could be detrimental to patient care.

B) De-certification of health facilities. H.R. 10460 would mandate the de-certification of facilities deemed "inappropriate." These decisions would be based on standards set by HEW.

MAG opposes mandatory programs based on standards set by HEW–believes voluntary programs much more appropriate, much more likely to be successful.

C) Revision of facilities construction. Title III of H.R. 10460 would remove present state authority under Title XVI to establish a state plan and set priorities for facility construction. The state would *not* be entitled to specific allotments of federal funds; instead, the Secretary of HEW would have the authority to establish priorities and to fund the projects.

MAG opposes amendments of Title III of H.R. 10460 that would remove state initiative in determining priorities for construction and funding.

(Note: The AMA has offered amendments to H.R. 10460 and S. 2410 concerning the extension of CON to physicians' offices, mandatory de-certification of health facilities, and Title III in H.R. 10460. H.R. 10460 is pending before the Interstate and Foreign Commerce Committee and S.2410 is pending before the Senate Committee on Human Resources.)

H.R. 9717 HOSPITAL COST CONTAINMENT ACT OF 1977 S. 1391

Both bills do the following:

A) Hospital cap provisions—a cap (approximately 9%) would apply to in-patient hospital review increases of non-federal hospitals.

MAG feels this hospital cap would set an undesirable arbitrary ceiling and adversely affect quality of care.

B) Capital expenditure limits and certificate of need would be set; a limit would then be portioned among certain states. Under S. 1391 a two-year moratorium on construction would be required. Also required under S. 1391 is extending certificate of need to "major medical equipment" (equipment exceeding $150,000 in aggregate over a two-year period to physicians' offices.

MAG feels a national ceiling on capital expenditures would arbitrarily limit needed improvements. De-certification and the extension of CON to physicians' offices is unwarranted and will result in a decline in quality care.

C) H.R. 9717 contains provisions wherein the Secretary of HEW would have authority to establish utilization rates of hospital services and occupancy rates of hospital beds. These standards would be *mandatory* on all HSA's.

MAG feels the closure provision of H.R. 9717 would concentrate power in the hands of the Secretary of HEW to set arbitrary "need" determinations in local areas and could destruct access to quality care whereas, currently we, in Georgia, determine what is best for Georgians, not the Secretary of HEW.

S. 705: H.R. 6221 CLINICAL LABORATORY IMPROVEMENT ACT OF 1977

This proposed Act redefines a clinical laboratory which would include a physician's office irrespective of whether he has a laboratory for diagnostic tests or examinations.

MAG believes the implications of this proposed amended definition are so far reaching that it should not *be adopted. We do* not *believe that collection facilities (as are most physicians' offices) should be deemed clinical laboratories, thus subject to provisions of this act. We urge no amendments to the definition that currently exists defining clinical laboratories.*

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RC/RD PD-JA-1699-2-P (8-76)

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History of H.B. 1246—Confidential Communications of Medical Records

RUSTY KIDD, *Atlanta**

The fascinating fate of one MAG-sponsored bill—which illustrates the importance of MAG members contacting their Senators and Representatives . . .

In the spring of 1977, numerous physicians contacted the Medical Association of Georgia regarding communications they had received from attorneys requesting the medical records of certain patients. These requests did not include the consent of the patient in question and under Georgia law, physicians were required to turn over patients' records. MAG attorneys researched the legal questions as to the responsibility of the physician to turn over patients' records without their consent.

The matter was referred to the MAG Legislative Committee who researched it and drafted sample legislation which would amend Georgia law to extend the confidential and privilege communication that all Georgia psychiatrists currently have to all licensed Georgia physicians. This sample legislation was then presented to the MAG Board of Directors who approved the legislation and requested the MAG Legislative Committee seek passage of this matter.

State Representative Wilbur Baugh of Milledgeville agreed to introduce the bill, ultimately called the Confidential Communication bill, H.B. 1246. It was introduced on January 9, 1978, the first day of the 1978 session. The Speaker of the House of Representatives assigned H.B. 1246 tm the House Judiciary Committee. This committee is comprised of some 21 members, 19 of whom are attorneys, one individual in law school, and one woman whose husband is an attorney.

Representative Baugh and MAG approached the Chairman of this Committee, Representative Wayne Snow of Rossville, and asked for a hearing on H.B. 1246. The full House Judiciary Committee met Tuesday, February 7, at 4:30 p.m. to debate the bill. At this time, Representative Baugh and a MAG spokesman presented to the Committee the need for legislation of this type. The main thrust of arguments in favor of H.B. 1246 was the right of the patient to have complete control of who has access to his medical records. Comments were made that it was not the business of any third person to seek and obtain a patient's file without the patient's consent. It was stated physicians were increasingly being put on the spot by attorneys in Georgia misrepresenting existing laws in seeking information on individuals without their knowledge. The committee, at this time, agreed with the concept of H.B. 1246 and passed the bill out of committee with one dissenting vote.

February 9, at 11:10 a.m., H.B. 1246 was up for discussion and a vote by the full 180 members of the Georgia House of Representatives. At this time, Representative Baugh, Representative J. Roy Rowland, Dub-

* MAG's Director of Legislative Activities.

THE ORIGINAL MAG BILL
(H.B. 1246)

Here's how the bill originally read, as sponsored by MAG and introduced by Rep. Baugh:

To amend Code Section 38-418, relating to confidential communications, so as to provide that communications between a physician and a patient shall be privileged; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

Section 1. Code Section 38-418, relating to confidential communications, is hereby amended by striking from paragraph 5 thereof the word:

"Psychiatrist",

and substituting in lieu thereof the words:

"Licensed medical doctor",

so that when so amended Code Section 38-418 shall read as follows:

"38-418. Confidential communications, etc.—There are certain admissions and communications excluded from consideration of public policy. Among these are:

1. Communications between husband and wife.
2. Between attorney and client.
3. Among grand jurors.
4. Secrets of state.
5. Psychiatrist Licensed medical doctor and patient."

Section 2. All laws and parts of laws in conflict with this Act are hereby repealed.

lin, Representative Max Kaley, Marietta, Representative Randy Karrh, Swainsboro, and others took the microphone in the chamber of the Georgia House and spoke in favor of the passage of H.B. 1246. Several attorneys rose in opposition to this bill and stated that the passage of such legislation would greatly encumber the access to records needed in certain court cases, etc.

But Representative Baugh prevailed: the House passed H.B. 1246 by an overwhelming vote of 130 to 18.

The next step in the life of H.B. 1246 was its transmittal from the Georgia House of Representatives to the Georgia Senate, where it was assigned by Lieutenant Governor Zell Miller to the Senate Human Resources Committee, February 10. At 9:00 a.m., February 23, this committee met and unanimously approved H.B. 1246.

On February 27 at 3:00 p.m., the Georgia Senate took up debate and consideration of H.B. 1246. State Senator Culver Kidd of Milledgeville and Senator Norwood Pearce of Columbus led the fight to seek passage of this measure. Several attorneys in the Senate, led by Senators Tom Allgood and Jimmy Lester, of Augusta, and Senator Peter Banks, of Barnesville, led the opposition to H.B. 1246. The bill was debated in the Senate for roughly 1½ hours, at which time the above mentioned attorneys adopted an amendment to the bill which gutted the entire measure and went so far as to *exclude* the confidential communications psychiatrists already have! The bill, as amended, passed that afternoon. A motion was made for reconsideration and said bill was reconsidered the following morning, February 28.

Under the reconsideration vote, the first order of business was a motion to delete the adverse amendment that had been accepted the day before. This amendment was deleted from H.B. 1246. At this time, the attorneys asked for consideration of a floor substitute. Parliamentary procedure requires all substitutes to be acted upon first and if a substitute is defeated, then consideration is continued on the main bill. The floor substitute was considered, was debated, and was passed over the objections of the Senators speaking in favor of the original bill.

The Legislative Committee of MAG immediately took the floor substitute to MAG's attorney's office to seek advice and counsel on how this measure would affect our membership. Our attorneys advised us that this bill needed additional language and if additional language were adopted, would be better than current existing law. With this in mind, MAG requested the House of Representatives, through Representative Baugh, to disagree to the Senate version of H.B. 1246. In so doing, a conference committee was appointed comprised of three members of the House of Representatives and three members of the Senate.

MAG submitted to this conference committee the exact language requested by MAG counsel. The conference committee adopted this language. Monday, March 6, the Senate agreed to the conference committee report. Somehow, between the Senate Secretary's office, and the House Secretary's office, the conference committee report was misplaced and could not be found. The MAG Legislative office, staying on top of this measure, realized the House had not agreed to the Senate version and began

In the Senate, an amendment passed which excluded psychiatrists from confidentiality protection. The original bill failed passage by *only four votes*.

inquiring to every office in the Capitol as to the whereabouts of the conference committee report. Tuesday, March 7, being the last day of the legislative session for 1978, made it incumbent upon MAG to determine the whereabouts of this conference committee report. At 10:15 p.m., on that day, the House of Representatives adopted the conference committee report to H.B. 1246, which now puts this bill, as adopted by both the Georgia House and the Georgia Senate, on the Governor's desk for his signature.

The Governor has 30 working days to veto any legislation. If within that length of time this bill is not specifically

CONFERENCE COMMITTEE SUBSTITUTE TO H.B. 1246

Here's how it finally passed:

To amend Code Section 38-418, relating to confidential communications, so as to provide that communications between a physician and a patient shall not be released except on patient's written authorization, court order or subpoena; to provide immunity to physicians releasing information pursuant to the provisions of this Act; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

Section 1. Code Section 38-418, relating to confidential communications, is hereby amended by redesignating the first paragraph thereof as subsection (a) and adding a new subsection to be designated subsection (b), to read as follows:

" (b) No physician shall release any information concerning a patient except on written authorization of the patient or in the case of a minor by his or her parents or duly appointed guardian ad litem or appropriate court order or subpoena; provided further that any physician releasing information under written authorization of the patient or under court order or subpoena shall not be liable to the patient or any other person.",

so that when amended, Code Section 38-418 shall read as follows:

"38-418. Confidential communications, etc. (a) There are certain admissions and communications excluded from consideration of public policy. Among these are:

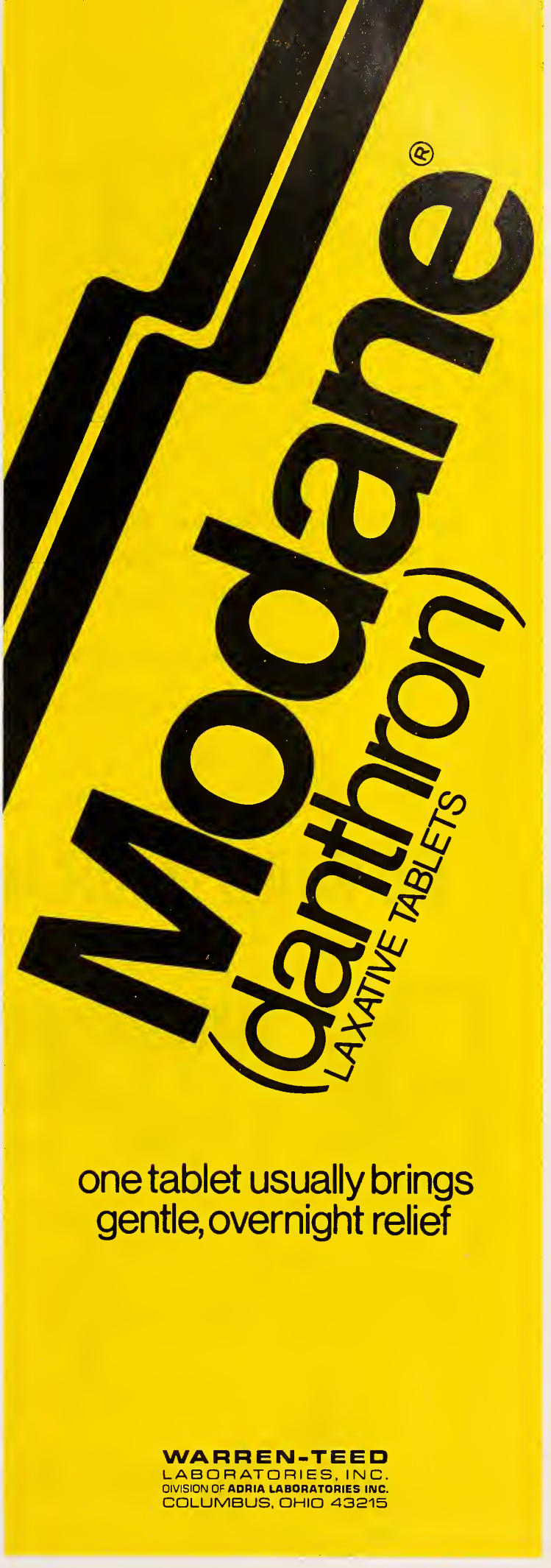
1. Communications between husband and wife.
2. Between attorney and client.
3. Among grand jurors.
4. Secrets of state.
5. Psychiatrist and patient.

(b) No physician, licensed under Georgia Code Chapter 84-9, shall be required to release any medical information concerning a patient except on written authorization or other waiver by the patient or on appropriate court order or subpoena; provided further that any physician releasing information under written authorization or other waiver by the patient or under court order or subpoena shall not be liable to the patient or any other person; provided further that the privilege shall be waived to the extent that the patient places his care and treatment or the nature and extent of his injuries at issue in any civil or criminal proceeding; provided further that section (b) of this Act shall not apply to psychiatrists.

Section 2. All laws and parts of laws in conflict with this Act are hereby repealed.

vetoed, then it can become law without his signature.

Hopefully, after reading the life history of this bill which is important to all Georgia physicians, you will wonder why *you,* a Georgia physician and member of MAG, did not take an active part in contacting your State Senators and State Representatives regarding the passage of the original version of H.B. 1246. If you had contacted your State Senator regarding the original bill, it probably would have been passed as originally requested by MAG. The original bill failed passage in the Senate by only *four votes! Was one of these four votes your State Senator? Did you contact him?*



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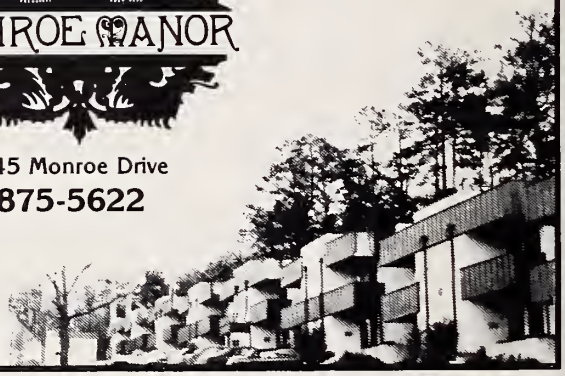
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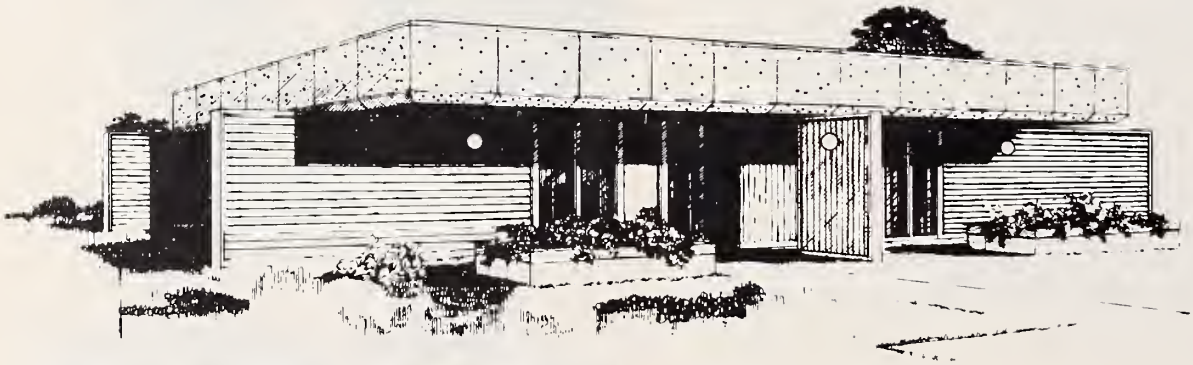
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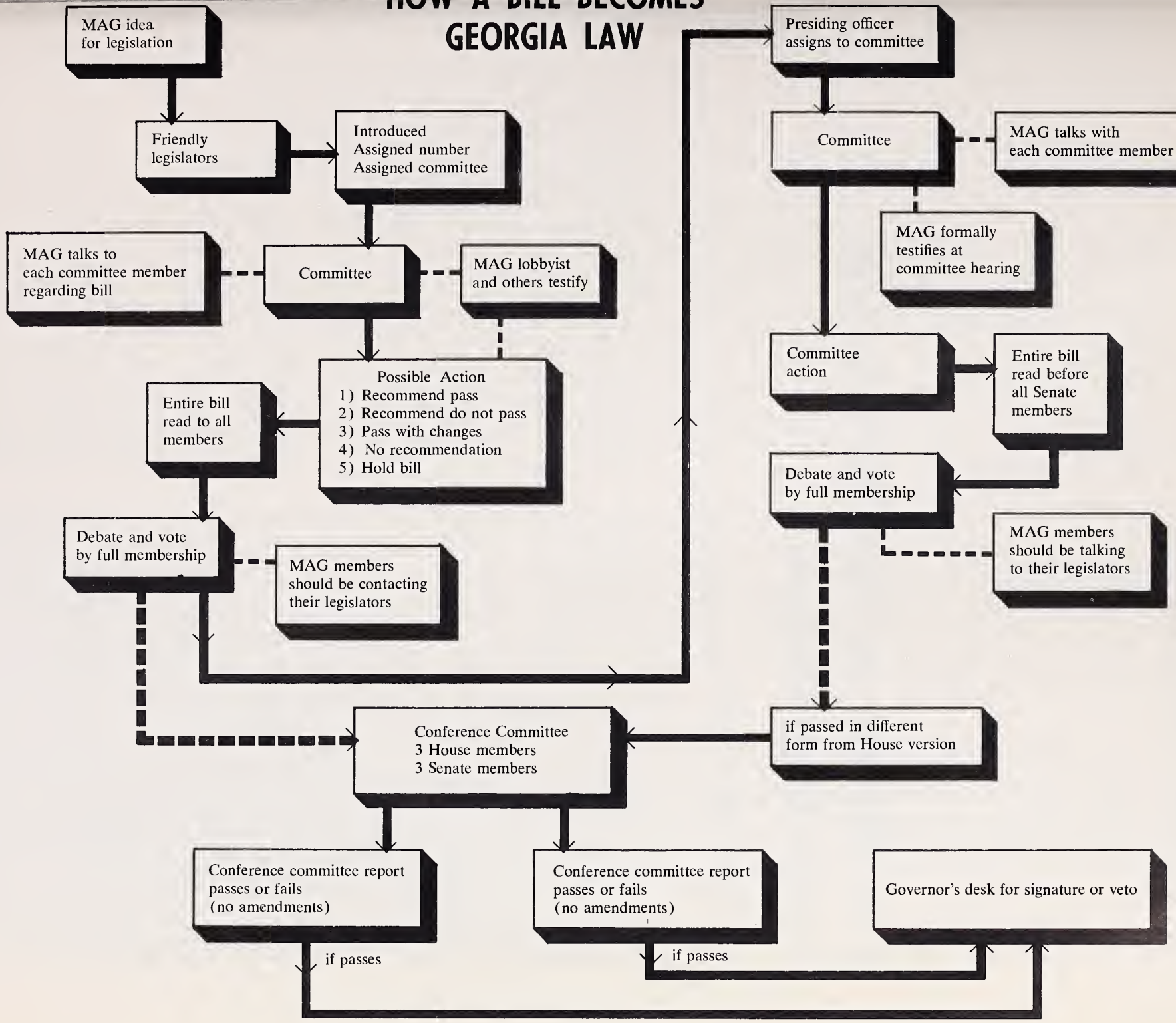
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HOW A BILL BECOMES GEORGIA LAW



One doctor's account of his experiences serving as "Doctor of the Day."

The Doctor of the Day in the State Legislature

R. A. GRIFFIN III, M.D., *Cartersville**

THE CURRENT PROGRAM sponsored by the MAG to provide a "Doctor of the Day" in the State Capitol has been a very beneficial program since its inception. It continues to improve every week of every legislative session. It does not limit itself to any one medical specialty but should entail the exposure of all specialties.

The gratitude expressed by the legislators both publicly and privately is a reward far in excess of the amount of effort involved in this privilege. Later in this article, I will try to outline a typical day in the experience of the "Doctor of the Day."

The availability throughout the Metropolitan Atlanta area of physicians, hospitals and medical services is brought to a focus through the "Doctor of the Day" program. Naturally, many of the state legislators, in fact most of them, are from outside the greater Atlanta area, and when they come into town they probably do not have a physician with whom they are familiar enough to call upon on short notice. Instead, they are familiar with the physician they normally use at home and they may have either difficulty reaching him or difficulty having him reach someone for them.

Each time one serves as the "Doctor of the Day," he is introduced formally in the House of Representatives and in the Senate Chamber. During the times that I have been introduced, I have been fascinated by the number of individual legislators who come up and shake your hand as you are entering or leaving the chamber, not to solicit your vote but to express their appreciation for your being there and for your interest in their well-being.

The "aid station" is manned by a very helpful and charming young nurse named Ms. Jan Hudson. She takes a lot of the work off the doctor. She knows the telephone connections for anything that one might need, including hospital services, pharmacy services, ambulance services or consultation. She has a knowledge of her inventory of "sample drugs." Many of the legislators like to have their blood pressure taken routinely and she handles this for them. I found an exceptional number of legislators who were convalescing from some medical or surgical illness in the process of performing their duties. These gentlemen were particularly grateful to have someone to discuss the current status of their illness. It is difficult for them to return to their homes for follow-up care during the time the legislature is in session. If they can check with a physician on the spot, he can advise them as to whether they should go ahead and make the effort to seek out their primary physician for follow-up care or whether it might be feasible to postpone their next visit until it is a little more convenient.

Naturally, we are all interested in the current legislation and want to know which specific bills might be under discussion. I am sure it is a big help to the MAG Legislative Committee to have a physician there who inadvertently is creating good will and making the legislators receptive to the suggestions and request of our Legislative Committee. As we all know, the tireless work of Dr. James Kaufmann is the most effective phase of our legislative activity and he also strives to see that the "Doctor of

* P.O. Box 764, Cartersville, Ga. 30120.

the Day'' program is effective and workable.

A rundown on a typical day in the life of the ''Doctor of the Day'' goes like this: You arrive at the Capitol in time to be on the 4th floor (location of the aid station) by 9:00 a.m. Be sure to give yourself at least a half hour to find a parking place. Once you arrive at the aid station and meet the nurse, a trip will be made to an office in an adjacent area for a name tag, which reads, ''Dr. XYZ, Doctor of the Day'' which is to introduce you to people that you may serve that day. Then you will have the opportunity to see if there are any patients for the morning. There may be well-wishers there, or greeters, as well as people who are relatively sick. Once this duty is accomplished, you will then be escorted around to the Senate and House of Representatives for your introduction. There you will be introduced by the presiding officer in each respective chamber, as well as by your local legislator there. You will then have the opportunity to make a few remarks to each House publicly. It is beneficial to have a few remarks in mind before you are before this august body; otherwise, you can find yourself in a rather speechless position. It seemed apparent to me during my period of time at the Legislature that a long speech was not something that the legislators were endorsing.

Following this introduction, you return to the aid station, because by now the power of advertising has occurred and generally you have drummed up some business by your visit to the chamber. You can then go ahead and visit with or assist patients that have come to the aid station. When that is completed, it is probably lunchtime. Occasionally it is feasible to have lunch with your respective legislators or some other group that you might be interested in sharing some discussion with.

Following lunch, you return to the aid station to see if any additional business has arrived. If no one is in need of your assistance at that time, you may want to visit the legislative chambers again to audit the discussion that is going on there. You generally remain on duty until each House of the Legislature has adjourned for the day.

I continue to receive letters of gratitude from members of the legislature.

In summary, I find it to be extremely worthwhile, both for the MAG as well as for me personally to have served as ''Doctor of the Day'' in the legislature. I certainly got a greater understanding of their problems (and I do not particularly mean their medical problems) by serving in this capacity.

Naturally, when legislation is introduced that is contrary to the best interest of the MAG, one may occasionally find derogatory remarks made about practicing physicians, perhaps because of their busy schedule or because of their lack of interest or lack of cooperation. This certainly is a good rebuttal for such charges.

It would certainly be my recommendation, that if you can find the time, to contact Rusty Kidd and sign up. Serving as ''Doctor of the Day'' to the state legislature is a worthwhile and very enjoyable experience.

Physicians who served as Doctor-of-the-Day this year

Beverly B. Sanders
Macon

Gene G. Davidson
Rome

Ernest Jones
Covington

Milton I. Johnson Jr.
Macon

George E. Malcom
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A Florida doctor describes the evolution and benefits of his state's medical examiner system . . .

A Statewide Medical Examiner System

JOSEPH H. DAVIS, M.D., *Miami, Florida**

LEST THE TITLE IMPLY that statewide medical examiner systems need be similar in organization or administrative control, be assured that this is not so. Rhode Island, half the geographic area of Dade County, Metropolitan Miami, cannot be compared with Georgia or Florida. In fact, the smaller state systems are nothing more than variances of large county systems. Most arose when metropolitan population concentrations required a full-time professional approach to medical-legal death investigation. The disparity in quality and uniformity of service between the well-served metropolitan areas and adjacent rural areas results in demands for improvement from those areas less well served.

Such was the situation in Florida. The initial medical examiner systems in Florida were established in the early 1950's in the southeastern large population centers. These were county oriented. Their strength arose from the independent authority of a pathologist-medical examiner to perform autopsies and carry out investigations pertaining to violent, sudden, and unexpected deaths without interference from other governmental agencies. The Dade County (Miami) office was fulltime with central facilities and a centralized toxicology laboratory. The Broward County (Fort Lauderdale) was parttime in scope with toxicology service obtained from Dade County. Eventually, Boward County developed a full-time, centralized service. Other populous counties followed this pattern, so that Florida, with its 67 counties, developed a variable degree of medical examiner service.

The Florida Medical Association realized that the greatest problem with the status quo was lack of uniform quality. It established as a legislative goal the concept of a single state statute which would remove any artificial legal barriers to improvement. In 1968 the FMA called a meeting at the State Capitol. Invited were representatives of every conceivable professional organization or agency which was affected in whole or in part by the presence or absence of medical examiner service. All law enforcement organizations, funeral directors, prosecutors and the bar associations, insurance organizations and medical sub-specialties were invited to make comment. Thoroughly discussed were the needs, concepts, and disappointment or satisfaction with the state of current affairs. A bill, modeled after the Dade County act, was presented to the legislature. An ad hoc committee of the FMA was appointed to review this and make recommendations. The Florida Society of Pathologists estab-

* Dade County Medical Examiner, 1050 NW 19th St., Miami, Fla. 33136.

lished a similar committee. Each pathologist within the state was queried as to involvement, if any, with medical-legal death investigations. In addition, the counties which each pathologist served were designated. The State Comptroller records were reviewed and inquests expenditures, if available, were obtained. Both committees met jointly.

At the initial joint meeting there was representation from pathologists who performed part-time or occasional medical-legal autopsies, medical examiners, and other physicians familiar with the legislative process and the intricacies of state government.

A surprising observation was that the state already, de facto, had developed a "system." The pathologists in the population centers tended to serve the surrounding counties. Established medical examiners likewise exerted an influence beyond adjacent county lines. When a map of the state was prepared, it was found that there were a few totally blank spots usually representing the extreme in lack of population density.

The goal of the committee members was a state law which would provide for quality medical examiner service without legal barriers. Certain objectives were listed in order to meet this goal:

1. The law and its implementation must not decrease quality and availability of service where such already existed in exemplary status. Medical examiners were not to be held at the lowest common denominator.

2. The law should provide for medical examiner investigations independent of police or prosecutor control.

3. Districts should be provided. An analysis of the demographic, economic and political diversity of the state readily established the need for local autonomy in order to solve local problems. The needs and the personnel to meet these needs were quite different in the Miami area as compared with the northcentral, sparsely populated regions of the state.

A "chief" medical examiner could not possibly assume responsibility for individual case investigations in a state second only to Georgia in area. Few had realized, until this time, that the half-way point between Key West (Florida) and Chicago (Illinois) was *Pensacola, Florida.* In addition, the shortage of pathologists qualified to perform forensic pathology consultations on a grand scale precluded this concept. Furthermore, the traditional political strength of Florida was local, not state. From a practical standpoint, the closer the examiner was to the investigation, the more efficient he could become.

"The basic principle is *local autonomy* following the guidelines established by a unified statute."

4. Each district medical examiner must be a pathologist. A major medical diagnostic procedure is the autopsy. The doctor of medicine with training in pathology is far and above the best qualified individual to utilize autopsy procedures. More important, however, is the fact that the complex interactions of disease and injury—physiological, chemical and structural—require medical expertise for proper interpretation. Only a small percentage of necessary medical-legal autopsies involve simple, uncomplicated injuries in previously healthy subjects. The majority necessitate careful medical correlation.

The Florida law was written to a great extent by practicing forensic pathologists who had both the urban and the rural needs in mind.

Legislative committee hearings covered these and other points. The bill was enacted as Chapter 406, Florida Statutes, in 1970. The act provides for a commission with regulatory authority. The commission designates the district boundaries, nominates the district medical examiners, assists in coordination and problem solving, and acts as the central data repository. The law provides for an extensive definition of death to be investigated. The medical examiner is authorized to investigate and perform autopsies and laboratory tests as he deems necessary in the public interest. Districts vary in funding according to their needs. Some operate on a fee-for-service, others on a retainer basis, and the remainder of the medical examiners are full-time salaried employees operating within central facilities.

A difficult problem was the placement of the commission within the administrative structure of state government. Eventually, it was placed in the Department of Health and Rehabilitative Services, although it retained its autonomy and is free of adverse influence by the staff of the administrative organization. Explorations were carried out to see if it might better fit within the Office of the Attorney General or under the auspices of the Supreme Court. The location of this commission is constantly under study and reevaluation.

The chief advantage of the law was to remove any artificial barriers to good service. Each district stands on its own merits with responsibilities and authorities clearly defined. In the event of failure, it is easy to determine responsibility on the basis of personalities, finances, or both. In about two years, all districts were defined; pathologists had been persuaded to serve within the system, and it was underway. It became evident that those districts with less than strong prosecution and police services tended to continue with similar lack of assertion on the part of the medical examiner. The converse was true elsewhere. In 1974, supplemental funds were appro-

priated by the state to augment local funding. The monies were earmarked for service improvement but were not restrictive and were also allowed to be carried through from one fiscal year to the other. This permitted some districts to build central facilities and others to acquire needed equipment and personnel. The total impact of this program is not yet determined but it is readily apparent to those of us who have observed the Florida scene that the improvement is remarkable and readily apparent.

The Florida system is a combination of natural evolution with the law being written, to a great extent, by practicing forensic pathologists who had both the urban and the rural needs in mind. It exists as a model for those geographic large states with scattered centers of population. The basic principle is local autonomy following the guidelines established by a unified statute. Cooperative ventures between districts is permitted and encouraged. Interaction between the medical examiners exists throughout the state.

For the first time in its history, Florida is now able to embark on programs of data acquisition, blood alcohol studies in deceased drivers, and service programs pertaining to such problems as sudden infant death. Furthermore, with no major input of federal programs or monies, the medical examiners have managed, for the most part, to keep up with the improvement of police services which resulted from the extensive Law Enforcement Administration programs for training of police. The centralized bureaucracy is nil. In fact, the central staff was two plus a secretary and is currently one plus a secretary. The monies to run the system are spent locally with a full guarantee that the best available cost benefit is assured.

Physician's Recognition Award Recipients

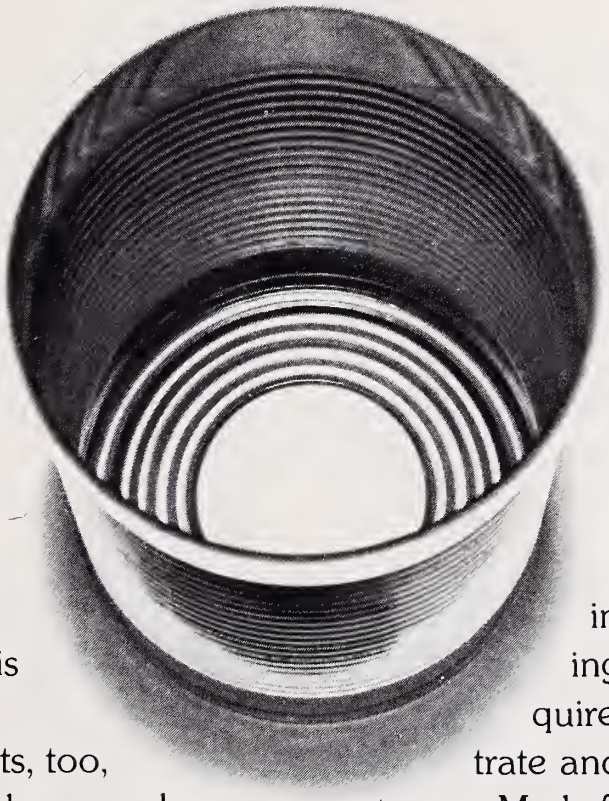
LISTED BELOW *are those physicians in Georgia who earned the AMA's Physician's Recognition Award during the period January 1 to February 15, 1978.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

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Peer review is fast becoming the new crisis of the medical profession.

The Anguish of Peer Review

CLYDE B. ROUNTREE, M.D., *Decatur**

I WRITE THE FOLLOWING NOT from learned knowledge or vast experience, but from personal anguish precipitated by peer review involvements.

Regulations by local, state and federal lawmakers and bureaucrats who know nothing of medical care continue to escalate so that one rule is often outdated by another before the former is implemented. Private insurance carriers are increasing demands for unnecessary information. Malpractice claims and awards are increasing as a result of news media sensationalism and the legal profession's continuance of the contingency fee fiasco. The Joint Commission on Accreditation of Hospitals continues to press for written delineation of staff privileges (which presents tremendous technical difficulties) and also recommends annual physical and mental examinations. The AMA, individual specialty societies and boards, and individual hospitals are pressing for 150 continuing education hours per three years. "Due process" is on everyone's lips, but no one defines it. Medicare/Medicaid regulations, PSRO, ethics and grievance committees, consumer advisory groups, etc. loom and threaten.

Frustrated by these nameless, faceless specters, bewildered physicians quickly realize that long hours of stressful review work brings no financial compensation, no thanks, frequent criticism and exposure to legal retaliation; we turn our anger inwardly and fight among ourselves. All this adds to the difficulties of peer review.

Medical peer review cannot be adapted to previous medical/educational systems since the physician has already demonstrated his professional competence by possession of his credentials. Written and verbal examinations have only minor validity in their reflection of medical practice competence. The old system of chart review is antiquated (bad doctors can produce good charts) and utilization review is no better and, even when done correctly, is tremendously expensive. Individual case outcome review is inadequate. Waiting for alleged malpractice complaints by patients is after the fact. We find no written guidelines and little past experience. These riddles are not our fault. This enigma is the evolution of medicine.

As physicians, our medical training and ethics have taught us our responsibilities in the treatment of disease and the relief of suffering. Traditionally, we also have been taught not to judge our fellow man. And yet, we ourselves were trained (and justly so) to be self-critical of our own medical judgments at all times. In judging other doctors, we recognize and acknowledge, "I have made mistakes and there but for the grace of God go I." We all fear witchhunts.

Self-evaluation is by far the most effective form of regulation; yet, review of other physicians is relatively simple. After an adequate period of time and association, good doctors can recognize substandard practice in others. They know! But the problem is, what is to be done? Just giving an opinion is no longer a completely acceptable reason to limit or terminate a physician's practice.

Medicine is still largely based on "art," i.e. individual medical judgment, and nbt based on scientific facts that can be recorded and numbered. Medicine cannot be adequately practiced by using statistical tables.

Doctors are being forced on all sides to adapt the traditional medical model in order to fit into a quasilegal/judicial system where "facts" are supreme and the adversary system ofnEnglish justice prevails. We are expected to learn and use complicated bureaucratic and legal language.

Our heads spin, pitch and roll; we shuffle our feet; we rotate reviewers and what is the outcome? Doctors who have the courage to attempt peer review place themselves somewhere between God and a twelve-man jury. Will peer review remain at this stage until overtaken by consumer groups, governmental agencies and the legal profession? If so, peer review will expire and outside control of medical practice will be full-born.

"Life is short, the art long, timing is exact, experience treacherous, judgment difficult." Hippocrates, c. 460-400 B.C.

* Chief of the Medical Staff of the DeKalb General Hospital, 2701 N. Decatur Rd., Decatur, Ga. 30033.

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What Physicians Should Know about Special Education

MELVIN E. KAUFMAN, Ph.D., and WAYNE L. SENGSTOCK, Ed.D., *Atlanta

The options available for the education of exceptional children are presented. These can provide the basis for a better understanding of the social, educational and emotional needs of these patients.

DURING THE PAST TEN YEARS, more children have received special educational services than at any time in this nation's history. The U.S. Bureau for the Educationally Handicapped indicates that there is a total of 4,310,000 children presently receiving some type of special education service.

In any clinical practice, the physician will encounter parents and teachers who talk about their children who have "learning disabilities" or "behavior disorders," as well as those who are "educable" or "trainable" mentally retarded. Further, school reports may make reference to "self-contained" classes, "resource" rooms, "itinerant" teachers, as well as a variety of other specialized but sometimes confusing terminology. In light of the significant number of exceptional children who are referred to physicians, it becomes increasingly important for the well-informed practitioner to become acquainted with some of the definitions of major categories currently being used to classify exceptional children, as well as to understand the principal types of services being offered by special education.

Learning Disabilities, Behavior Disorders, and Mental Retardation

In terms of current labeling procedures, the greatest number of exceptional children are classified as either behaviorally (emotionally) disordered, learning disabled or mentally retarded. The term learning disabilities has been defined by Dr. Barbara Bateman (1965) as follows: Children who have learning disabilities are those who manifest an educationally significant discrepancy between their estimated intellectual potential and actual level of performance related to basic disorders in the learning processes, which may or may not be accompanied by demonstrable central nervous system dysfunction, and which are not secondary to generalized mental retardation, educational or cultural deprivation, severe emotional disturbance, or sensory loss (p. 220).

Learning Disabled Children are the same children who were formerly labeled as having dyslexia, word blindness, specific reading disability, dysphasia and central processing disorder. The definition implies that the children have the potential for average or better intellectual functioning, but are failing to achieve as they should in school. The behaviors most often described by children labeled as having learning disabilities include hyperactivity, perceptual-motor deficits, emotional lability, crossed dominance, and disturbances of attention, memory and perception. The most frequent academic problem involves reading difficulties.

As can be seen, the term learning disabilities is a fairly loose one that may be applied to a number of children whose major difficulty seems to be a lack of achievement in school among children of average or better intelligence. Despite this lack of precision in definition, a number of children with learning problems may be helped by providing appropriate educational support experiences, the specifics of which will be presented in the final section of this paper.

Kaufman's definition of a behavior disorder is a "state characterized by inefficient psychological functioning producing an excess of behaviors which we label as 'maladaptive' and a deficit in behavioral skills which we call 'adaptive.' " There is some subjectivity involved in determining those behaviors one decides to call adaptive or maladaptive. However, when undesirable or maladaptive behaviors are discussed, it refers to such excesses as marked aggressiveness, shyness, impulsivity, inflexibility or chronically high levels of anxiety. Likewise, a deficit in behavioral skills is indicated by the absence of a reasonable capacity to cope with the various problems of

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daily living, e.g., absence of age appropriate restraints on behaviors in social settings, inability to make and keep friendships, and a reasonable degree of flexibility in adapting to minor changes in the environment. Mild behavior disorders may interfere with school performance, interpersonal relationships, and personal happiness of the child. Moderate and severe behaviors usually produces very significant disruption in all spheres of functioning, e.g., intellectual, emotional, and social spheres.

The educable mentally retarded (EMR) are those who exhibit a potential for profiting from a special school program encompassing academic, social, and occupational learning. It is assumed that such children eventually will be able to function independently by the time they are adults.

EMR's fall into the IQ range of 50-70. It is estimated that 89% of all the mentally retarded fall into the EMR category. Etiologically speaking, most EMR's do not exhibit any physical stigmata and there is no gross evidence of CNS dysfunction. In addition usually one parent and most of the siblings are similarly retarded. The term cultural-familial mental retardation is used to describe most of the EMR's. While a majority of EMR's are designated as cultural-familial, there is a smaller group of patients who fall into this category and the condition due to a variety of pre-, peri-, and post-natal illnesses and injuries affecting CNS development. As the definition indicates, educational programs tend to teach basic academic, social, and vocational skills. Reading and simple calculation are taught among many other academic skills that can be acquired. Given the benefit of the full spectrum of special educational opportunities, most EMR's develop into productive and relatively independent adults who are capable of satisfactory community adjustment.

The trainable mentally retarded (TMR) are those who do not exhibit a potential for profiting from the program for educables, but who demonstrate the ability for learning skills of self-care, social adjustment, and economic usefulness to a degree that will allow them to function partially independently by the time they are adults. These individuals are capable of applying their learned behaviors in either home or more sheltered environments. The approximate IQ range of TMR's is 30-50. Etiologically, the group shows great diversity; however, the largest single group of TMR's are diagnosed as having Down's Syndrome. There is much greater likelihood that such children will have accompanying sensory and motor handicaps than in the case of EMR's. At the present time, educational services are offered to TMR's either in public schools or health agency sponsored facilities. With the development of appropriate community support services, fewer TMR's are being institutionalized than in the past.

Special Education Services

Special Education services for the handicapped have greatly expanded in the past decade. Exceptional children often require different levels of remediation, curriculum, and educational strategies than those required in working with other children. In the past decade, a technology of teaching has been developed which offers a series of systematic instructional procedures which are flexible enough to meet almost all situations. Special Education services range from those which can be delivered within the context of the regular classroom to those which require placement in special classes, hospitals and treatment centers. Described below are the major educational services provided for exceptional children within the framework of the school. Not included are essentially similar services which may be provided by residential schools or hospitals.

Self-Contained Class

Traditionally, classes for the mentally retarded have been organized so that such children spend most, if not all, their time in self-contained classrooms. To a lesser degree, the same can be said for behaviorally disordered children and learning disabled children. In a self-contained class the child is enrolled with a specially trained teacher with whom he/she spends most of the day. Such children also participate with normal children in art, music, physical education, homemaking, as well as other classes where they may compete on a relatively equal footing. Self-contained classes for the handicapped tend to have small pupil enrollments. The teacher is free to devote more individual attention to the academic and behavioral development of the student and thus maximize the child's potential. Professionals in the field have been debating about how many exceptional children should be integrated into classes with their normal peers and receive special assistance provided by resource teachers. The latter strategy is called "mainstreaming."

Resource Rooms

If the handicapped child is enrolled in a regular classroom and goes to a special room for individualized instruction, this special room is generally called a resource room. The resource room is preferably equipped with equipment such as language masters, teaching machines and devices which record academic responses. The special education resource room teacher is particularly trained in the areas of diagnosis, continuous evaluation, and precision teaching. It is in the resource room that the child receives precise assessment of entering behaviors and the developments of skills necessary for functioning in the regular classroom.

The general tendency is to place children with mild handicaps in a resource room. A decided advantage is that the child is able to remain in a regular class with normal peers and still have the benefits of individualized and specialized training. A possible disadvantage is that the partial isolation may emphasize the handicapped child's deviation. By and large, however, children with mild handicaps make up the largest proportion of handicapped children, and possibly it is considered preferable to enroll


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Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file. Mead Johnson Pharmaceutical Division.

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Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.
Quibron-300— Adults: 1 capsule every 6-8 hours.
Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

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them in regular classes and to provide special attention for their disabilities. This attention is usually in the form of supplementary experience provided in small groups or on an individual tutorial basis in a resource room.

Itinerant Personnel

There are a variety of personnel who may deal with the handicapped child on an itinerant basis. Special Education personnel such as speech correctionists, social workers, school psychologists, remedial reading teachers, and learning disability specialists may visit the child and his teacher at regular intervals. Such specialists may serve several schools while traveling over a wide area. For example, a speech therapist or special education teacher, may see a handicapped child several times a week while an itinerant school social worker might visit the child's school or home once a month. The youngster spends the major part of his time in the regular classroom and participates with the itinerant specialist for relatively short periods. The itinerant special education teacher usually brings special materials for the child and confers with the teacher on how to use them most effectively. In rural areas, where handicapped children are scattered over a wide area, itinerant programs are particularly valuable.

The authors have not elaborated on similar services that have been established on pediatric services in general hospitals or small residential schools or institutions. More and more general hospitals are employing educational specialists to provide for the special needs of children who must be hospitalized. With regard to residential treatment facilities for exceptional children, the service offered most frequently is that of a self-contained class.

We have seen that a wide variety of handicapped children are being provided special education services. Such services offer a spectrum of opportunities including: (1) providing assistance to the regular class teacher while the child receives all of his education with his chronological aged peers; (2) staying in a regular class, but having short scheduled periods of special educational instruction individually or in small groups in a resource room, or (3) being placed in a self-contained class with a special teacher who is equipped to meet the unique demands of maximizing academic and personal development of the special child.

This paper has presented a brief sketch of recent developments affecting the education of exceptional children. It provides a basis for understanding the social, educational, and emotional needs of handicapped children. Thus the physician is better able to understand the variety of children served and the options available for serving them.

Reference

Hellmuth, James (Ed.): *Learning Disorders* (Vol. 1). Seattle, Special Child Publications, 1965.

CHECK YOUR ROSTER LISTING

Compilation of the 1978-79 *Roster of the Medical Association of Georgia* is now underway. We want it to be as accurate as possible, and we need your help.

After May 1, 1978, no additions, deletions or corrections can be made.

Please check your listing in the *1977-78 Roster* and make sure it is as you want it to appear in the new *Roster*. Check spelling, address, specialty and status. If any changes are needed, please put them *in writing* and send them to: Karyn Donehoo, Membership Records Administrator, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta, Ga. 30309.

Thank You!

Deadline: May 1, 1978

The advantages of this procedure are discussed, along with an illustrative case report.

Plateletpheresis as a Preventive Measure to Complications of Asymptomatic Cases of Idiopathic Thrombocythemia

JOYCE LARISON, MT(ASCP)BB, and M. M. FATTEH, M.D., *Augusta

IDIOPATHIC THROMBOCYTOSIS is one of the megakaryocytic myeloproliferative disorders. It could represent the initial state of polythemia rubra vera. An increased platelet count in such conditions can endanger a patient's life by thrombosis of vessels of vital organs or hemorrhages in them.

A patient was referred to us with idiopathic thrombocythemia who had a borderline white blood cell count and red blood cell mass. On admission, her platelet count was 3,055,000 per/mm^3. Although she did not have evidence of thrombosis or hemorrhages, plateletpheresis was carried out as a preventive measure. This reduced the platelet count from 3,055,000/mm^3 to just under one million in four pheresis sessions. Each pheretic procedure lasted less than two hours. Such rapid decreases in platelet counts suggest that this procedure could be a useful tool in the treatment of asymptomatic patients with high platelet counts. This could prove to be a life-saving preventive measure.

Case Report

A 68-year-old white female was referred for evaluation of thrombocythemia. She was first admitted in another hospital with complaints of backache. Her routine work-up revealed a very high platelet count. She was referred to our hospital for further evaluation.

Upon admission, her initial platelet count was 3,055,000/mm^3. Her white blood cell count was 11,300/mm^3 and her red blood cell count was 5.6 million/mm^3. Her hemoglobin was 13.6 gm%. The patient was thought to have idiopathic thrombocythemia. A possibility of an early stage of polycythemia rubra vera was not ruled out. The patient was not on any chemotherapy. Despite this high count, she did not have any hemorrhagic disorder or evidence of thrombosis of vessels of vital organs. Her clotting studies were normal. As a preventive measure to thrombosis and hemorrhagic complications of this disease, plateletpheresis was carried out in four sessions.

Method

A pheresis harness was attached to a 225 cc disposable collecting bowl aseptically. Component collection bags were also connected to the outlet part of the harness. Approximately 1cc of ACD formula A was delivered for every 8 cc of whole blood added to the bowl. The blood pump was activated to a flow rate of 60 cc/minute until blood was half way from the rim of the bowl. At this point, the collection rate was reduced to 20 ml/min. Platelet collection was carried out for 45 seconds beyond the red color appearing at the exit tubing. As soon as half of the bowl was empty and the blood with plasma was flowing back to the donor at a steady rate, another pass was begun. The total time for the procedure was approximately 2 hours. Before and following plateletpheresis a hemogram and platelet count was performed. The total amount of ACD used and total number of pheresis passes made were recorded.

Results during the pheretic procedure recorded are as follows:

* Ms. Larison is supervisor of the Blood Bank and Dr. Fatteh is chief resident in the Blood Bank, Medical College of Georgia School of Medicine, Dept. of Pathology, Augusta, Ga. 30901.

Date	Pts. Est. Blood Volume	Hct. %	Vol. WB Ext. Cycle	Pre-Pheretic Platelet Count mm³	Post-Pheretic Platelet Count mm³	Total ACD Used	No. of Pass	Plts. Concentrate
6-23-77	3,721 cc	48	375 cc	2,280,000	1,620,000	275 cc	6	512 cc
6-25-77	3,721 cc	45	400 cc	2,077,500	1,500,000	325 cc	6	380 cc
6-27-77	3,721 cc	48	375 cc	1,410,000	980,000	325 cc	6	350 cc
6-30-77	3,721 cc	48	375 cc	1,600,000	1,060,000	350 cc	6	380 cc

* To calculate the actual amount of whole blood extracted for each pass, the calculations are as follows

$$\frac{\text{225 cc (small bowl size)} \times \text{0.80 (Hct within bowl)}}{\text{Hct of Donor}} = \text{whole blood extracted pass}$$

† The estimated blood volume for each pheresis performed on this patient was 10%.
To estimate the % of blood extracted (should not exceed 13%) in relation to the donor's total blood volume, the calculation is as follows:

$$\frac{\text{Total volume whole blood extracted in one pass}}{\text{Total blood volume of donor}} = \text{\% circulation volume extracted}$$

After the third pheresis, the platelet count was 980,000/mm³. Since evidence of increased red blood cell mass was lacking to establish a diagnosis of polythemia rubra vera, the patient was not placed on chemotherapy. The patient had lost approximately 33 cc of blood following a bone marrow biopsy, which reduced her hemoglobin to 11.8 gms%. It was thought that because of this low hemoglobin, her red blood cell production may have been curtailed.

To enhance red blood cell production, she was placed on iron therapy. However, iron therapy did not increase her red blood cell mass. Her platelet count rose to 3,150,000/mm³. It was decided at this point to commence chemotherapy (Lukeran). If the chemotherapy did not control platelet production rapidly, it was also decided to perform plateletpheresis simultaneously. The patient did respond to the chemotherapy; therefore, further plateletpheresis was not required. The last platelet count result done on the patient was 500,000/mm³.

Discussion

High platelet counts are seen in patients with polythemia rubra vera, idiopathic thrombocythemia, granulocytic leukemia, and myelosclerosis with myeloid metaplasia. Bone marrow in this patient did not show myelosclerosis, but it showed an increased number of atypical megakaryocytes and slight increase in number of nucleated red blood cells. These findings were more in favor of the diagnosis of either idiopathic thrombocythemia or an early state of polycythemia rubra vera. However, lack of conclusive evidence of increased red blood cell mass and a high white blood cell count were not in favor of the diagnosis of polythemia rubra vera. An absence of an enlarged spleen and lack of fibrosis in the bone marrow ruled out the possibility of myelosclerosis. Absence of myelocytic activity in the marrow was against the diagnosis of granulocytic leukemia.

The plateletpheresis has been carried out as a therapeutic measure in cases of polythemia rubra vera and idiopathic thrombocythemia.[1, 2, 3] It seems that, in the literature, evidence of using this technique as a preventive measure is not found. From personal communications with the hematologists, we understand that some people do not advocate plateletpheresis for such patients. They feel that plateletpheresis may provide an additional stimulus for platelet production. This may lead to an even higher platelet mass than previously existing. Although we do not disagree with this view, we feel that prophylactic plateletpheresis is a harmless, quick procedure. It also removes considerable number of platelets and has a beneficial role in the treatment of thrombocythemia until definite therapy can be instituted.

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Forensic and Environmental Pathology: A New Beginning in Georgia

FORENSIC PATHOLOGY IS ONE of the oldest subspecialties of medicine, having its American origin in the late 1800's at Harvard. Today in the United States there are some 300 certified forensic pathologists, but less than 200 of these practice the specialty primarily. Recently, due to media publicity—including T.V. series "Quincy"—and through extensive exposure to the specialty in postgraduate medical education training programs, forensic pathology has attracted some of the best physicians into the few programs that exist. Financial improvements have helped and prestigious universities have sought approval as training centers.

The forensic pathologist as a medical specialist serves primarily as medical examiner for the state, county or local government. The medical examiner, as such, is an independent agent of the people. His office should be independent as well and unaffiliated with other government bodies such as the District Attorney or other law enforcement investigative bodies in the area. The impact of a properly run death investigation system and an office dedicated to protecting the public through identification of health and industrial hazards is receiving careful study in Congress. A Congressional subcommittee was formed solely for the purpose of setting standards for a nationwide death investigative system.

Georgia's system for the investigation of death has not significantly improved since its inception. Even Alabama has recently taken steps to upgrade its medical-legal investigative system, correcting inadequacies which still exist in Georgia.

In 1978 Georgia is still dependent on a coroner-medical examiner hodgepodge. The coroner, a quasi-judicial officer, qualifies for his office *by simply being 18 years old.* No further qualifications are required to assume the important task of heading the investigation of the cause and manner of death. These findings have great impact on the life and health of persons other than criminals in the community. Statistics show these findings affect the community, state and even larger areas in which the case arose by modifications of public health laws, national transportation safety board regulations, vehicular design standards, building codes, insurance premiums on accident and life policies, and recognition of diseases causing morbidity and mortality. For such an important task, certainly the physicians who document these changes should possess basic qualifications. As Dr. Davis has stated in his outstanding article (see page —): "the complex interactions of disease and injury—physiological, chemical and structural—require medical expertise for proper interpretation." This is afforded only by those who have made forensic medicine a primary practice or specialty. The state of forensic pathology today is more complex and sophisticated than even five years ago and requires a completely different approach for all concerned.

In the metropolitan Atlanta area, the Fulton County Medical Examiner's Office has reached preliminary agreement with Emory University School of Medicine to create a residency approved by the American Medical Association and American Board of Pathology for training in the subspecialty of forensic pathology. This will allow the

training of two pathologists annually for future service to Georgia. A cure for the state's forensic problems is in sight.

It is the obligation of the Medical Association of Georgia to review and scrutinize the practice of death investigation as it exists today. Certainly there are efforts to provide basic crime scene investigation on obvious homicides and on selected violent cases; however, these categories make up only *one third* of the total. The medical examiner is and should be primarily concerned with non-criminal cases today. He has shown his value in murder. He must now look to the killer—environment. As many as 5 million persons were exposed to asbestos dust while building ships in World War II. Their incubation time bomb is ready to explode. The medical examiner must become the watch-dog for health hazards.

Certain organizations, such as the Georgia chapter of the Sudden Infant Death Foundation, are genuinely concerned about the lack of investigation in SIDS cases outside of metro Atlanta. A representative from the southeastern corner of our state at a recent meeting stated that the bureau of vital statistics in her area had no listing of a single sudden infant death for the previous year. Sudden infant deaths certainly occur in that area. They were not investigated or properly coded. Local chapters of the SIDS Foundations in many states have been responsible for upgrading medical examiner laws and systems. Such is the case in Georgia. This group of people is now launching a campaign to effect changes toward a proper medical-legal death investigative system statewide.

Forensic and environmental pathology is a complex specialty of medicine requiring the medical expertise of properly trained physicians working in a statutory system to properly investigate death cases and their impact on community health. The state of Georgia, because of its geography and population, lends itself nicely to the formation of a regional medical examiner's system. Such a system need not be a financial burden on the taxpayer, but would require only minimal state funding to go forward. The basic framework for the medical examiner's act is incorporated in the Georgia Post Mortem Act. Few changes would be required to create a modern, more efficient system. The problems inherent in the office of coroner are not insurmountable. Georgia, if it were to follow the steps of other states which have modified or eliminated the coroner system, could assume its rightful position in forensic science nationally. A basic requirement for the office of coroner, assuming that it survives, is that the person holding this office be qualified to practice medicine.

The great interest generated by many public and community organizations in our state and the creation of a new residency program at Emory in Forensic and Environmental Pathology should serve as a rallying point for the MAG. It is too late for physicians to be leaders in this field where once they were pioneers. There is still time to be faithful followers.

Joseph L. Burton, M.D.
John R. Feegel, M.D., J.D.
Fulton County Medical Examiner's Office, Atlanta

Little Bighorn

THROUGHOUT HISTORY, we remember those small groups annihilated by overwhelming enemy forces. Custer's last stand, the Alamo and the Spartans at Thermophylae continue to capture the imagination of succeeding generations. As individuals, we try to imagine the thoughts and feelings of the actual people involved in these tragic dramas. The serious or professional historian develops a broader view of these events. Historical reconstruction more often than not views the events as tragic preventable mistakes as opposed to heroic necessities. Lack of communication with available support and/or logistical problems precede the heroic sacrifice.

Members of the Georgia Psychiatric Association did not wish to be remembered for

their valiant, albeit futile, stand against various intruding forces. Every effort has been made to take advantages of the services available through the Medical Association of Georgia. The MAG staff and the MAG Legislative Committee provide excellent advance intelligence reports concerning possible attack from all points of compass. MAG carefully cultivates effective allies. In turn, the Georgia Psychiatric Association serves as a smaller scouting force maintaining a vigilant alertness on one area of the medical perimeter, providing information to MAG and also cultivating specific allies in strategic locations.

It has been an extremely rewarding experience to work closely with MAG over the past three years. A majority of the skirmishes have involved points of concern to the entire medical profession, such ashprofessional liability legislation, confidentiality and various aspects of third party payors. It has been tremendously reassuring to find sympathy, support and direct assistance from MAG when the particular perimeter of psychiatry has been threatened.

The chairman of the Georgia Psychiatric Association Legislative Committee has been warmly welcomed as a member of the MAG Legislative Committee. From this point of contact, coordination of mutual endeavors has been a pleasure to behold.

Those small groups determined to forage on their own will find their own "Little Bighorn"—leaving us only a memory.

J. A. Raines, M.D.
President, Georgia Psychiatric Association

Joint Board of Family Practice

BEGINNING IN 1974, the Georgia General Assembly was becoming increasingly concerned with the need for more physicians for the rural areas of the state. Recognizing that because of low population densities, most areas could not support a full range of medical specialists, the legislature turned to the specialty of family medicine. At first the legislature attempted to stimulate the training of increased numbers of family physicians through increased appropriations to the Medical College of Georgia. This effort did not meet with success.

At this point, the Georgia Academy of Family Physicians recognized that support of family practice would have to be realized through alternative funding mechanisms. There was much debate in the Academy about the relative merits of attempting to influence medical school curriculum or residency programs. It was felt that the orientation then present in the medical schools would be unlikely to create a commitment to family medicine, regardless of political pressure. The Academy therefore decided to obtain funding to make additional residency opportunities available for those desiring to enter the specialty of family medicine.

A legislative bill was drawn up by the Academy and presented to the legislature, resulting in House Bill 1756, which created a Joint Advisory Board of Family Practice to determine needs and create and/or support family practice residency programs around the state. The Board was composed of members of the Executive Committee of the Academy and the Dean of each medical school in the state with a department of family practice.

Because of the commitments made through MAG's House of Delegates, its Legislative Committee lent support to this legislation.

Without a dissenting vote, House Bill 1756 was passed in the 1976 session of the legislature and the Joint Advisory Board of Family Practice, thus created, began its mandated tasks. All of this was accomplished with intensive legislative contact

around the state by the Academy and the legislative expertise of the MAG's Committee on Legislation and Rusty Kidd.

In 1977, funding was made available in the amount of $275,000 to proceed with the work of the Joint Advisory Board. Adam Jablonowski was recruited from the MAG staff to be the administrator of this board in July of 1977 and since that time has been instrumental in helping achieve the Board's goals.

At about this time, Governor Busbee became personally interested in the Board; consequently, the Governor's budget presented to the 1978 legislature included $1,277,000 for family practice, indicating both an executive and legislative commitment to the goals of the Board.

During 1977, administrative problems arose because of the wording of HB 1756 and amendments were submitted to change the Board's name to the Joint Board of Family Practice, since the function of the Board was more than an advisory one. At this time other amendments were submitted and an additional family physician representative of the Georgia State Medical Association was added as a member of the Board. With the help of Rusty Kidd and his mentor, Dr. James Kaufmann, and Adam Jablonowski, the proposed legislation was followed through committee, passed by the House and Senate, and at the time of this writing is on the Governor's desk for his signature.

The Georgia Academy has no reason to believe that the act will not be signed by the Governor, enabling the Joint Board of Family Practice to receive funds from the legislature and utilize them to determine state family practice needs and to support programs to fulfill these needs.

The funds recommended by the Governor are essentially "line itemed" through the Board of Regents budget and as far as we know have remained intact through the Senate and House Appropriation Committees. The passage of the final Appropriation bill therefore should ensure that family practice residents will be turned out in unprecedented numbers in the state of Georgia for several years to come.

Stephen C. May, M.D.
President, Georgia Academy of Family Physicians
Vice-Chairman, Joint Board of Family Practice
and
Adam R. Jablonowski, M.P.A.
Administrator, Joint Board of Family Practice

National Legislative Successes in 1977

The AMA, state medical associations and county medical societies helped the medical profession achieve several significant legislative victories in 1977 that prevented further unwarranted government intrusion into the private practice of medicine.

Among the victories was the defeat of a Congressional sanction for Federal Trade Commission jurisdiction over non-profit organizations, including medical societies. Also defeated was the subjection of physicians' offices to certificate-of-need programs, as called for in several versions of hospital "cost-containment" proposals.

Stalled were Administration proposals for price controls on hospitals and a fixed national dollar limit on capital expenditures of health institutions.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, when signed into law by President Carter as PL. 95-142, contained several modifications achieved by the AMA. Among them were a narrowing of the definition of "shared health facilities," which originally included almost all group practices, and a waiver of Medicare-Medicaid review programs which duplicated PSRO activities.

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president's letter



It Would Be Laughable if It Weren't so Pathetic

THAT A GOVERNMENT would squander its citizens' money on such "vital government endeavors" as the following:

- $35,000 to chase wild boars in Pakistan.
- $70,000 to study the smell of the perspiration given off by Australian Aborigines.
- $28,361 paid to Turkey for an odor-measuring machine.
- $50,000 for studying the life views of the Guajiro Indians in Colombia.
- $37,314 to purchase for Morocco a potato chip machine.
- $6,000 for the study of Polish bisexual frogs.
- $85,000 to study the cultural, economic, and social import of rural road construction in Poland.
- $20,324 to study the mating calls of Central American toads.
- $121,000 to find out why people say "ain't."

Unknown amounts of money to print millions of pamphlets for indigent women stating that hysterectomy "brings peace of mind to many women who may also experience greater sexual pleasure after they have been sterilized." (The HEW subsequently excoriated surgeons for performing "too many hysterectomies" and withdrew the pamphlets.)

This is the same set of clowns who propose to tell the medical profession how to treat illness.

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Milton I. Johnson, M.D.

Milton I. Johnson, M.D.
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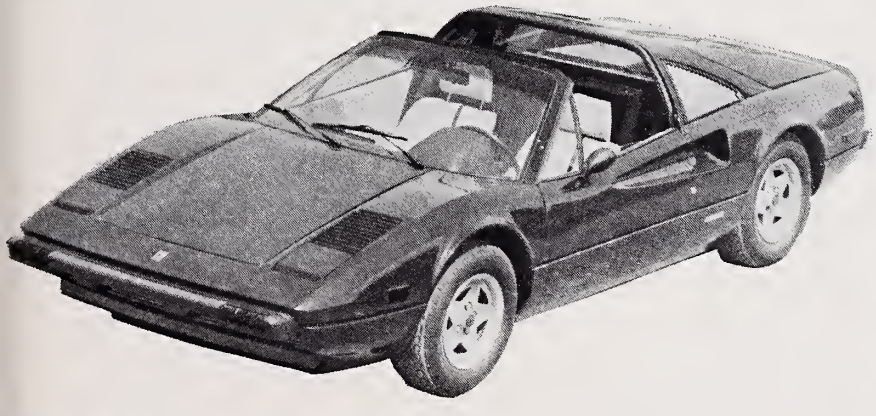
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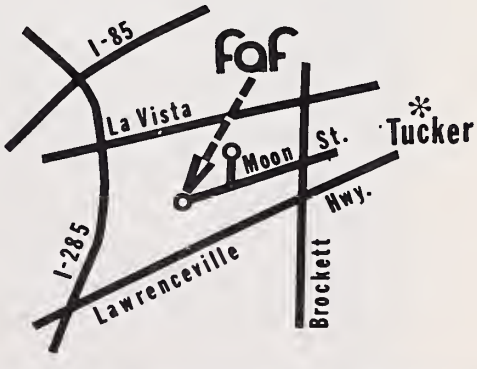
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I've told this before . . .

(Editor's note: A mystery is finally solved in this story by Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Disappearing Ducks

Two of us were fishing on one of the large north Georgia lakes. We "knocked off" about 10:00 a.m., because we were not catching any fish and it was hot.

We went to a nearby country store and bought the usual things that fishermen like for lunch—salmon, sardines, etc.—then joined two farmers under the front shelter that went out over the gas pump. They had also been fishing and were eating. We got to talking about this and that and the subject of small farm ponds came around—one of them had had an interesting experience.

He said that he had this little pond about 100 yards from the side of his house and that he liked ducks. He liked to see them on the water, liked to eat them and liked their eggs—so, he bought 12 white ducks. He would go down in the late afternoon, watch them from his bench there, feed them, etc. One afternoon, he could count only 11. This did not trouble him too much. But a few days later, there were only ten—a week later, only nine and now he became alarmed. Something was killing his ducks. First, he thought it was probably a fox, but he had several hounds who loved to chase a fox and he simply could not believe that a fox would dare come that close to his house. He thought of all kinds of varmints, including two-legged ones, but then there were still the dogs. The ducks were too big for a hawk. Nothing made sense. He lost another duck. . . .

Finally, late one afternoon, he was watching them as he threw corn out in the water 18-20 inches deep and watched them dive for it. Suddenly, there was a great clamor, the ducks cried in alarm and all of them came scurrying out of the water. After that, things settled, the pond was calm and placid and no ripples were seen. Further out were a few small air bubbles rising to the surface. When he counted his ducks, one was missing. He talked to his neighbors and friends about his problem. Finally one knowledgable man told him that he had some big turtles in his pond and offered to catch them for him—and he did. He baited large hooks with portions of chicken and caught two turtles that weighed about 12 lbs. each. Evidently they came up under a duck, swimming or feeding—grasped him, pulled him down.

From then on his ducks thrived. I asked him where the turtles might have come from. He said that he had no idea. His pond was only five years old and the nearest water was several miles away.

I have always felt like a "ninny" because I did not ask him why he liked duck eggs—but, that's what he said and I have no idea who he was or where he lived.

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The Right to Die in Georgia—Maybe Next Year

RICHARD H. VINCENT, *Atlanta**

FOR A FEW DAYS during the 1978 Georgia legislative session, it appeared likely that Georgians would be formally accorded "the right to die with dignity." Chances for passage appeared excellent for a number of reasons: First, the right to die with dignity is basically a part of the broader right of privacy in general—a right which enjoys an increasing level of popularity both in this state and elsewhere. Secondly, the proposed legislation was well drafted and would have substituted some degree of certainty and predictability in an area where uncertainty and unpredictability have been rampant. As the Legislature wore on, however, it became apparent that this was an idea whose time has not quite come as far as Georgia is concerned. The bill died in the Senate Human Resources Committee by a vote of 7-3.

Summary of the Bill

The bill (House Bill No. 1258) was popularly known as the "Living Will" or "Right to Die" bill. It reflected the general knowledge that modern medical technology has made the artificial prolongation of human life fairly commonplace, that the artificial prolongation of human life detracts from individual autonomy and patient dignity and sometimes causes unnecessary pain and suffering, and that the medical and legal professions currently operate under great uncertainty as to the legality of terminating extraordinary life-sustaining procedures.

Generally, the bill provided that any competent adult could execute a *directive*[1] to the effect that if he should have a *terminal condition,*[2] *extraordinary life-sustaining procedures*[3] would be withheld or withdrawn. (All italicized words in this article have specific and detailed definitions in the bill.) A *directive* was required to be witnessed by two disinterested parties and was required to be in a prescribed form to give expression to the *declarant's* legal right to refuse medical or surgical treatment and to accept the consequences from such a refusal.

A number of limitations and safeguards were included in the bill:

1. A *directive* could only be executed by a mentally competent adult.

2. A *directive* was given a limited duration of seven years from execution, and the effectiveness of the *directive* was specifically suspended during the course of any pregnancy.

3. Elaborate revocation provisions were included so that a *declarant* could, without regard to his mental state or competency, revoke the *directive* in any number of ways

* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner in the firm of Powell, Goldstein, Frazer and Murphy, General Counsel to the Association. His address is 1100 C & S National Bank Building, Atlanta, Ga. 30303.

(including tearing or destroying it or having someone else do so, issuing a written revocation, giving a verbal expression of his intent to revoke the *directive,* etc.).

4. A copy of the *directive* was required to be included in the *declarant's* medical record.

5. An additional medical representative witness was required in the event the *directive* was signed when the *declarant* was a patient in a hospital or skilled nursing facility.

6. A person who had not executed a valid *directive* was conclusively presumed not to desire the withholding or withdrawal of *extraordinary life-sustaining procedures* (except in an extremely limited case where a consent could have been given by certain specified relatives of the *declarant* as discussed below).

7. The bill specifically provided that it did not constitute legislative approval of abortions, mercy killings or any other kind of deliberate act to terminate life.

Under the bill, a validly executed *directive* would have had the following effect: First, no physician, hospital or skilled nursing facility acting in accordance with the requirements of the bill and withholding or withdrawing *extraordinary life-sustaining procedures* for a patient would have been subject to any civil or criminal liability, nor would he have been guilty of any unprofessional conduct. Secondly, the withholding or withdrawal of *extraordinary life-sustaining procedures* from a patient in accordance with the bill would not, for any purpose, have constituted a suicide. Next, the making of a *directive* was specifically prevented under the bill from inhibiting or impairing in any way the sale, procurement or issuance of any policy of insurance. Finally, the withholding or withdrawal of such procedures would not have operated to deny any additional insurance benefits for accidental death in any case where the *terminal condition* was the result of an accident.

Perhaps the most controversial portion of the bill was the provision under which, in certain instances, third parties could request the withholding or withdrawal of *extraordinary life-sustaining procedures* with respect to a terminal patient who had not executed a valid *directive*. Under the bill, if a non-pregnant patient with a *terminal condition* (a) had been comatose for at least 48 hours, (b) had been diagnosed as having an irreversible cessation of brain function and (c) had at least one *vital function*[4] being maintained by *extraordinary life-sustaining procedures,* then such procedures could be withheld or withdrawn upon the request of certain designated relatives. Although this provision may at first appear to permit a possible infringement on the rights of some comatose terminal patients, it appears to this writer that Georgia law would already permit the withholding or withdrawal of such procedures under the conditions described in the bill; *Ga. Code Ann.* §88-1715.1(a) provides that "a person may be pronounced dead if it is determined that the person has suffered an irreversible cessation of brain function."[5] It would logically follow that no physician would be required to commence or continue *extraordinary life-sustaining procedures* where the patient could already be pronounced legally dead.

In any event, when the bill died in the Georgia Senate, Georgia physicians with terminal patients were left to wrestle with the difficult questions they have struggled with in the past: Is there any legally safe way to withhold or withdraw *extraordinary life-sustaining procedures* to a terminally-ill patient whose death is otherwise imminent? Is there any legally safe way to put an end to painful and expensive treatment which serves only to prolong an otherwise imminent death of a terminal patient?

So far, in Georgia, the answer to these questions is still "no."

Notes

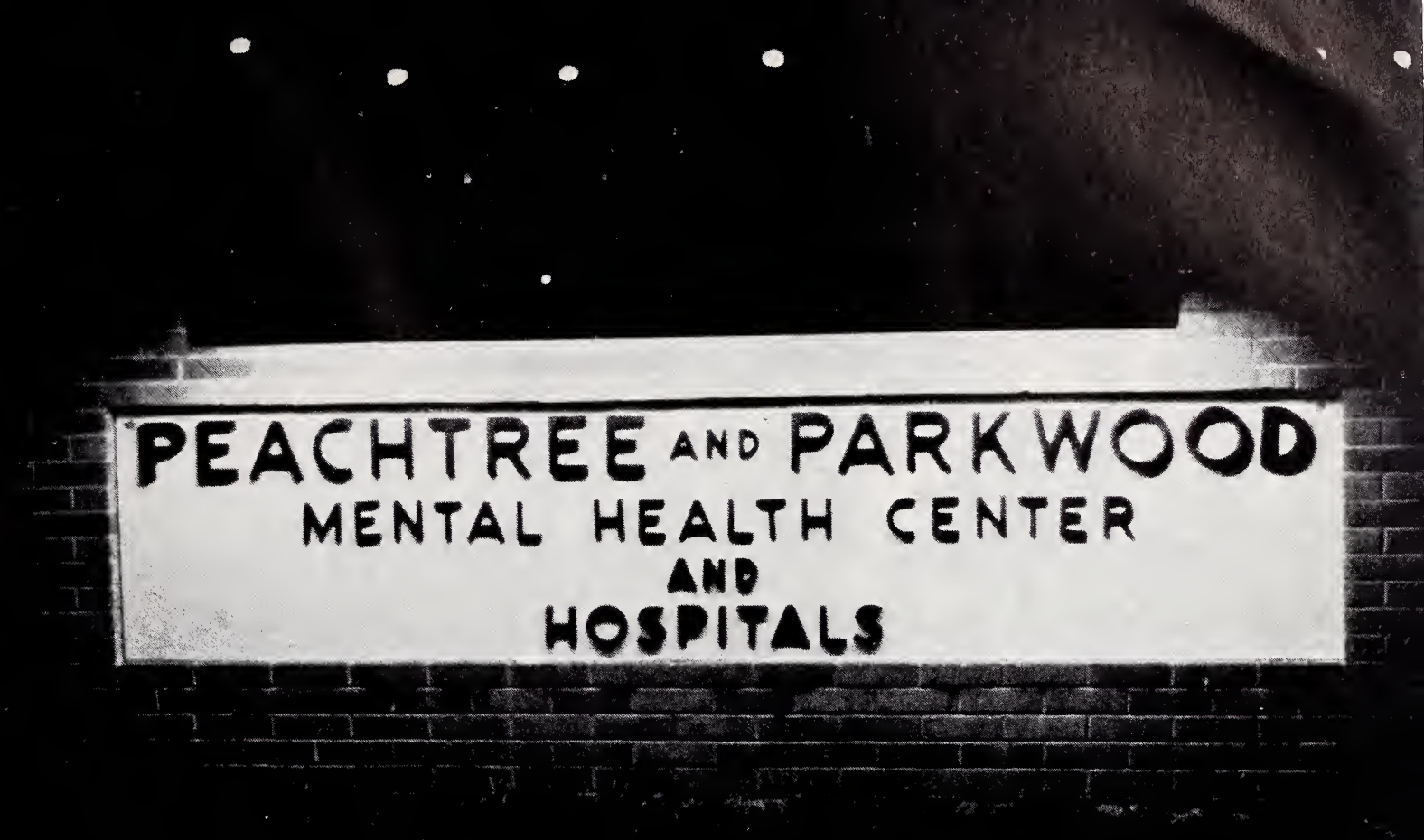
1. "*Directive*" means a written document voluntarily executed by the *declarant* in accordance with the other requirements of the bill.

2. "*Terminal condition*" means, as diagnosed and certified by the *attending physician* and one other physician who has personally examined the patient, a grave physical disability which is incurable and in which the patient is rendered incapable of cognitive processes with no probability of regaining them and for which the employment of *extraordinary life-sustaining procedures* would, within reasonable medical judgment, do nothing more than postpone for a short time the imminent death of the patient.

3. "*Extraordinary life-sustaining procedures*" means any medical procedures or intervention which utilizes mechanical or other artificial means to sustain, restore or support a *vital function,* and which are employed to maintain the life of a person suffering from a *terminal condition,* and which do nothing more than postpone the patient's more or less imminent death due to such condition. Such procedures do not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

4. "*Vital function*" means respiration, cardiac function, or alimentation.

5. *Georgia Code Annotated* §88-1715.1(b) (1975) goes on to provide for civil and criminal immunity for those acting in good faith in reliance on the quoted provision.



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heart page
heart page
heart page

SBE Prophylaxis

ROBERT M. PATTON, M.D., *Columbus**

"INFECTIOUS ENDOCARDITIS" is the preferred term over the more common and customary term introduced by Libman in 1912—"subacute bacterial endocarditis." "SBE" is too frequently used in describing a patient who has been sick for a few days and who may well have a fungal infection. Be that as it may, recommendations for physicians, dentists, and others for selected patients has been and will probably continue to be "SBE prophylaxis."

As we all know, the scope of endocarditis has changed significantly since described by Senac and Morgagni in the 18th century. Mortality in the pre-antibiotic era as well as the predominant organisms are not the same in the antibiotic/surgery era with increasing parental use of illicit drugs.

The disease remains perplexing—striking in unpredictable fashion and often with devastating consequences. Pathogenesis is not that well understood, so consequentially methods of prevention are controversial. The American Heart Association has published guidelines for antibiotic prophylaxis of bacterial endocarditis to provide assistance to the medical and dental practitioners. Since the last statement published in 1971, new information has become available and new concepts have been proposed, making revision of the statement advisable.

Based on recent studies, some of the regimens for adults that might be expected to have a large margin of safety for *oral procedures* are:

1—Penicillin G, 2,000,000 units plus Procaine Penicillin G, 600,000 units with Streptomycin 1.0 gms. IM 30 minutes before the procedure.

2—Vancomycin, 0.5 gms. IV 30 minutes before the procedure.

3—Cefazolin, 1.0 gram plus Streptomycin 0.5 grams IM 30 minutes before the procedure and again every 8 hours for 2 more doses.

4—Penicillin V (Phenoxymethyl2.0 grams orally 30 minutes before the procedure and then 0.5 grams every 6 hours for 2 more days.

At present, the American Heart Association recommends 72-hour prophylaxis, and until it modifies this position, it may well be prudent, medicolegally, to add to the above regimen as follows:

1—600,000 units of Procaine Penicillin IM on each of the 2 days following the procedure.

2—Vancomycin 0.5 grams IV every 6 hours for 72 hours.

3—Cefazolin 1.0 grams IM every 8 hours plus Streptomycin 0.5 grams every 12 hours for another 48 hours.

Erythromycin, for penicillin sensitive patients, in a dose of 500 mgs. orally every 6 hours for 72 hours, starting 1 hour before the procedure is probably a less effective prophylactic regimen than those listed.

Regimens likely to be effective for enterococcal endocarditis prophylaxis when per-

* Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

Dr. Patton's address is St. Francis Medical Park, 2300 Manchester Rd., Columbus, Ga. 31904.

forming surgery or examinations of the genitourinary/gastrointestinal tract are:

1—Vancomycin, 1.0 grams IV 30 minutes before the procedure.

2—Ampicillin, 30 mgs./kgs. plus Gentamicin, 1.5 mgs./kg. both IM 30 minutes before the procedure.

3—Ampicillin, 30 mgs./kgs. plus Streptomycin, 15 mgs./kgs. both IM 30 minutes before the procedure.

The regimens are listed in the order of effectiveness. To complete a 72-hour regimen, the Vancomycin should be continued in a dose of .5 gms. IV every 6 hours, the same dose of ampicillin would be repeated every six hours, the same dose of gentamicin every eight hours, and the same dose of Streptomycin every 12 hours, all for a total of 72 hours. Another regimen likely to be effective for enterococcal endocarditis prophylaxis is Aqueous Penicillin G 20,000,000 units IV daily with Streptomycin 1 gram IM every 12 hours or with gentamicin 1.5 mgs./kg IM every 8 hours, starting 30 minutes before the procedure. If oral therapy must be used, an appropriate regimen might be Ampicillin, 50 mgs./kg. plus 0.5 gms. of Probenecid and then 25 mgs./kgs. Ampicillin plus 0.5 gms. Probenecid every 6 hour along with Streptomycin 1 gm. every 12 hours. Gentamicin 1.5 mgs./kg. IM every 8 hours starting before the procedure may be substituted for Streptomycin. All schedules are adult doses.

The schedules outlined are more difficult than the previously recommended regimens, and in some cases impossible to apply to outpatients. Their chance of widespread acceptance are less than the previously recommended programs, and a lower application of prophylaxis may result.

The risk of endocarditis following a procedure is undoubtedly related to both the magnitude of bacteremia and the type of underlying heart disease. As an example, a tooth extraction probably results in a greater bacteremia than a single filling. Similarily, epidemiologic data suggests that patients with a prosthetic valve are at a higher risk than patients with prolapsed mitral valve. Additionally, consideration is to be given to the implication of endocarditis in an individual, e.g. endocarditis in a patient with a prosthetic valve is catastrophic in comparison to the usual case of endocarditis. If more rigorous prophylactic regimens are to be recommended in the future, considering the poor compliance with the current regimen, then an effort should be made to indicate in which patients and for which procedures it is most important.

There are limitations in extrapolating data obtained in animals to clinical results. Despite the acknowledged differences, animal studies have proved logical guidelines in devising regimens for prevention of bacterial endocarditis. Considering the widespread use of antibiotics if given for all procedures that cause bacteremia, the risk of drug reaction, the reliability of patient/physician adherence to protocols, and the constant inconvenience to the patient, careful reappraisal of the whole question of prophylaxis against bacterial endocarditis will continue.



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Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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SOCIETIES

The written history of the **Auxiliary to the Medical Association of Atlanta,** from its inception in 1923 to 1971, has been incorporated into the permanent records of the Atlanta Historical Society.

William B. Spann, president of the American Bar Association, spoke at the March 11 meeting of the **DeKalb Medical Society** at the Century Center Hotel in Atlanta.

PERSONALS

First District

Simon V. Speriosu, M.D., of Savannah, has been appointed clinical director of Georgia Regional Hospital at Savannah.

Third District

A resolution was adopted by the 1978 session of the Georgia General Assembly commending Montezuma physician **Tom Adams, M.D.,** for his years of service to Macon County.

Richland physician **Larry Brightwell, M.D.,** has been named chief of staff at Stewart-Webster County Hospital.

Simone Brocato, M.D., of Columbus, was named Boss of the Year by the Columbus Chapter of the American Business Women's Association.

A resolution was also adopted by the 1978 session of the Georgia General Assembly commending Montezuma physician **Carl P. Savage Sr., M.D.,** for his years of service to Macon County.

Fourth District

Stephen B. Edelson, M.D., of Decatur, is now a Diplomate of the American Board of Family Practice and a fellow of the American Academy of Family Physicians.

Decatur physician **Ralph A. Tillman, M.D.,** received the 1977 Julius McCurdy Citizenship Award at the annual meeting of the DeKalb County Medical Society in January. The award, established in 1974, goes to members of the medical profession for outstanding accomplishments outside their regular practice.

Fifth District

Donald O. Nutter, M.D., professor of medicine and associate professor of physiology at Emory University School of Medicine, has been awarded a Robert Wood Johnson Health Policy Fellowship for a year's study of federal health policies in Washington, D.C.

Sixth District

William A. Dodd, M.D., of Wrightsville, has been named chairman of the Medical Advisory Committee of the American Health Care Association.

Macon physician **George Henry, M.D.,** was elected to the American College of Psychiatry at their meeting in New Orleans earlier this year.

Macon physicians **Milton I. Johnson, M.D., Charles Lanford, M.D.** and **W. A. Williams Jr., M.D.** have all been certified by the American Board of Family Practice.

J. Benham Stewart, M.D., of Macon, presented a continuing education program in Tampa, Fla. before the American Society of Abdominal Surgeons Study Center earlier this year.

Seventh District

Gerald Kumin, M.D., of Marietta, has been appointed to serve on the Department of Medical Assistance's Advisory Committee for the Georgia Prospective Reimbursement Project.

Ninth District

Winder physician **C. B. Skelton, M.D.,** is the recipient of a "Citizen of the Year for 1977" award, presented by the Winder-Barrow Chamber of Commerce.

Martin H. Smith, M.D., of Gainesville, was installed as chairman of District IV of the American Academy of Pediatrics during the academy's annual session.

DEATHS

John Ernest Powell Jr.

John Ernest Powell Jr., M.D., 56, of Villa Rica, died February 16. A graduate of Emory University School of Medicine, Dr. Powell set up practice in Villa Rica in 1947, where he practiced throughout his life.

Surviving are his wife, a daughter, a son, his mother and a sister.

Letters to the Editor

Dear Sir:

The short article by Preston Ellington in February's *Journal* (page 131) was unusually eloquent and expresses a point of view I believe to be shared by many physicians. It is a pleasure to see writing of this caliber in the *Journal,* for which I would like to commend the author and the editor.

With all personal best wishes, I remain

Sincerely yours,

J. Norman Berry, M.D.
Atlanta

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Final classification of the less-than-effective indications requires further investigation.

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701



Anxiety...
Often a significant feature of irritable bowel syndrome*

The action of Librium®
(chlordiazepoxide HCl)

A significant advantage of adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

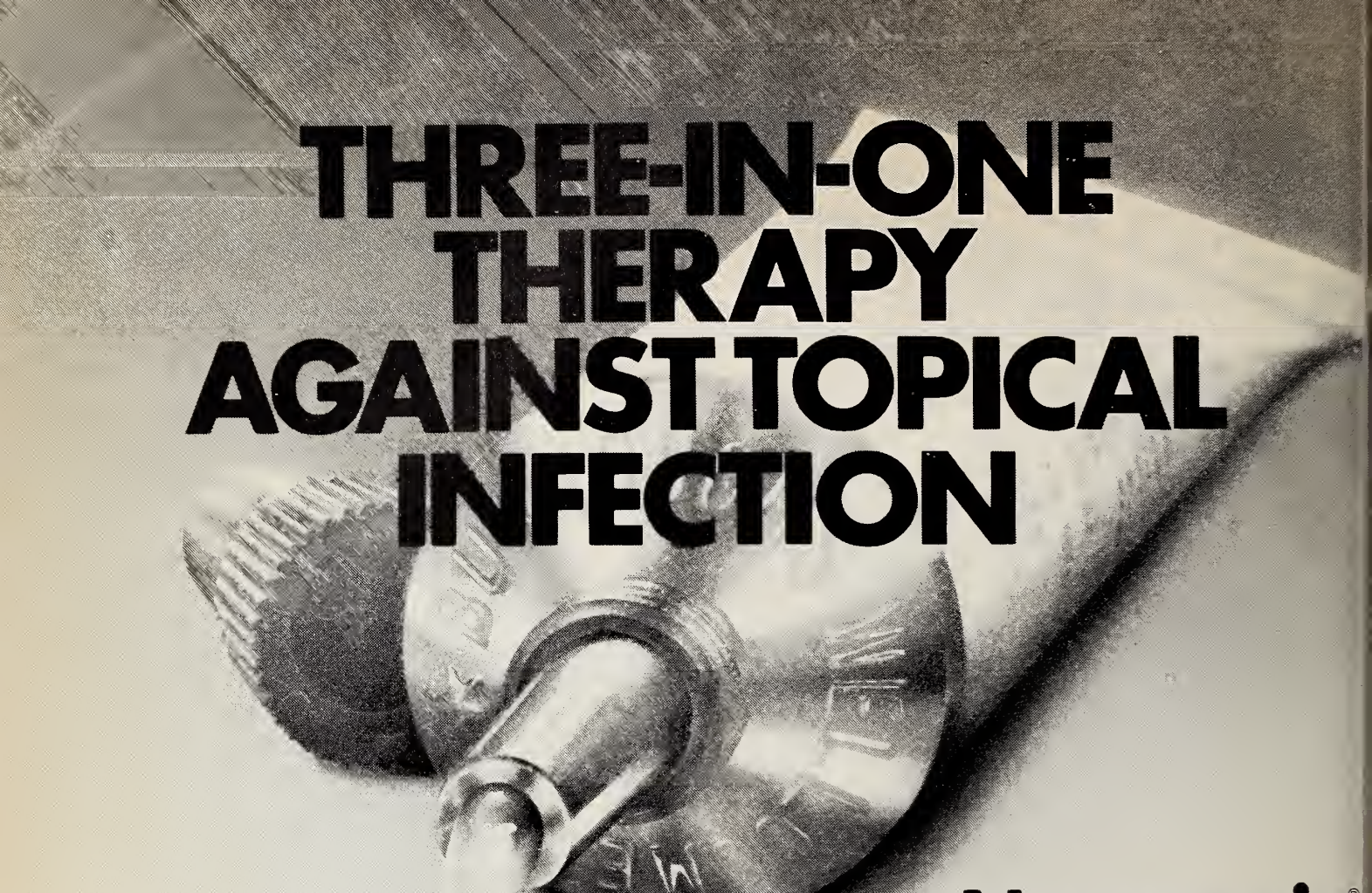
Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

ax has been evaluated as possibly effective for this indication.
se see brief summary of prescribing information on preceding page.

ROCHE

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

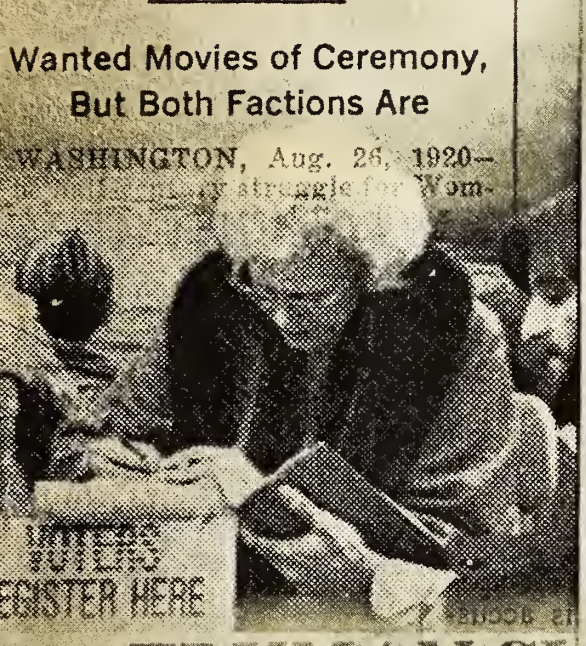
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Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws-He the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 1
The Social Security Bill, p
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SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

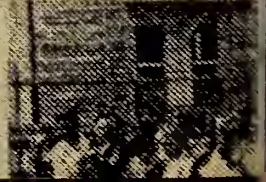
The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

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Whatever your BMW needs are, we can take care of them. We can sell you a BMW, or offer you a lease that includes a FREE LOAN CAR. We can take care of routine service, or handle any major repairs. We have our own body shop especially for BMW's. And we carry an excellent supply of BMW parts and accessories.

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PHYSICIANS AUTO LEASING SERVICE. A state-wide leasing service is offered to physicians and other health professionals. First Georgia Leasing gives preferred rates on luxury and prestige cars and leases all makes, foreign and domestic. Special rates quoted for multiple group-practice leases. Call Tom Lawless (404) 971-8838.

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MEDICAL OFFICE and Practice Available, now, equipped; lease basis; Cobb County, Near 5 open-staff hospitals. Call (404) 941-1300 or (404) 252-4133.

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FOR SALE: Six Gyn exam tables and stools; Wolf laparoscope with Fallope Ring Applicator and Rings; urine centrifuge; six lakeside carts; miscellaneous office chairs; goose-neck lamps. 404-252-9090 M-F 8:30-5.

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BEAUTIFUL GLASS PAVILION HOUSE for sale with 8 acres of land north of Atlanta. Only home like this in the state. Huge great-room; three fireplaces, one in massive kitchen; full studded basement. Call (404) 993-4260.

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital; 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Write Box 10-B % the *Journal*.

PHYSICIANS WANTED

SUNBELT COMMUNITY EMERGENCY PHYSICIAN—La Grange, only 60 miles southwest of Atlanta. Immediate opening for experienced emergency department staff physician in beautiful southwest Georgia setting. Fantastic recreational area! $45,000 plus benefits. Send curriculum vitae to Warren Ingalls, M.D., Director of Emergency Services, West Georgia Medical Center, 1514 Vernon Road, Box 1169, LaGrange, Georgia 30240, or call toll free 1-800-325-3982, Ext. 220.

ALL SPECIALTIES NEEDED. Immediate openings on the West Coast, Southeast or New England. Guaranteed assignment. No overhead. $33,000-$40,000 starting salary. Thirty days paid vacation. Noncontributory retirement system. Practice medicine not paperwork. For more information on U. S. Navy medicine, contact Chief Steve Shasteen in Columbia (803) 765-5991 or call toll-free 1-800-922-2824.

FAMILY PRACTICE, INTERNAL MEDICINE, URO, ORTH Surgeon, and Psychiatry urgently needed in Douglas, Georgia. Beautiful facility, assistance. Call or write Stephen Hall, Director Physician Relations, Medenco Hospitals, Inc., Box 3448, Houston, Texas 77001, toll free 1/800-231-2855 or 1/800-231-3024.

SITUATIONS WANTED

OPHTHALMOLOGIST—32, married, excellent university program completing cornea-anterior segment fellowship (all phases, including implantation and ultrasound); teaching experience. Prefers partnership or multispecialty group in Atlanta area. Reply to Box #3-A, % the *Journal*.

Money Available

For:

- **Established Doctors**
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- **Executives or Educators with salary of $20,000/yr. or more**
- **Airline Pilots**

Unsecured Personal Loans
$5,000 to $25,000, up to 5 years to repay
No prepayment penalties

Loans made anywhere in Georgia and in most other states. Handled by mail for your convenience.

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JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

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ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattac

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal trac

Please see reverse side for summary of product information.

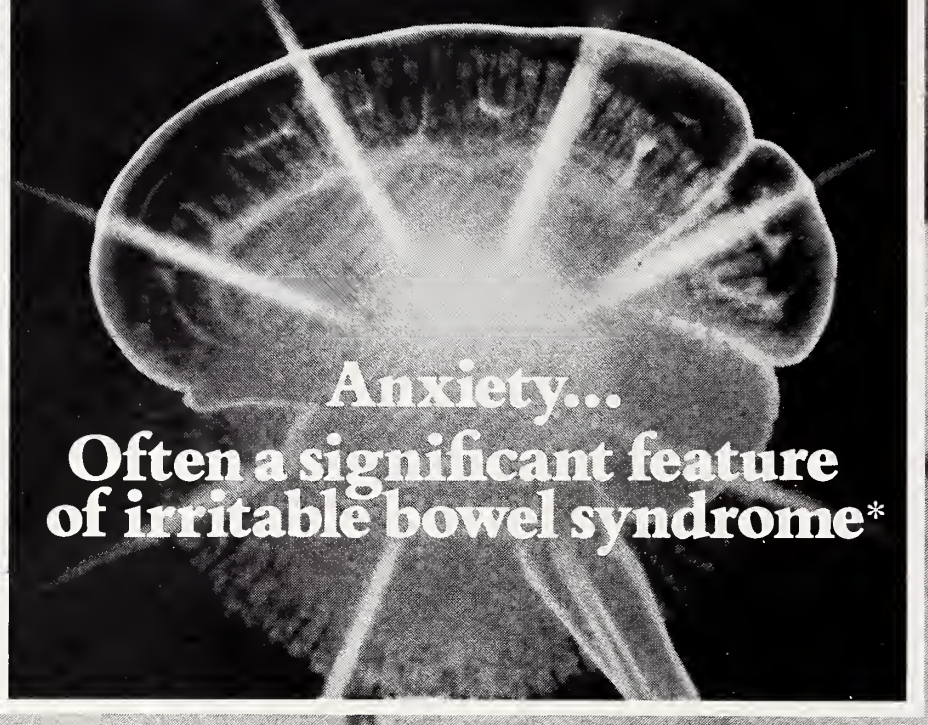
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Journal



Mucous plugs and bronchitis in association with asthma

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Anxiety...
Often a significant feature of irritable bowel syndrome*

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Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

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Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

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This month's cover story is about beclomethasone dipropionate. Drs. Frank M. Pickens and P. Bailey Francis talk about its value in the treatment of severe asthma, beginning on page 345.

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BRIEF SUMMARY OF
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ANTIMINTH® (pyrantel pamoate)
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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

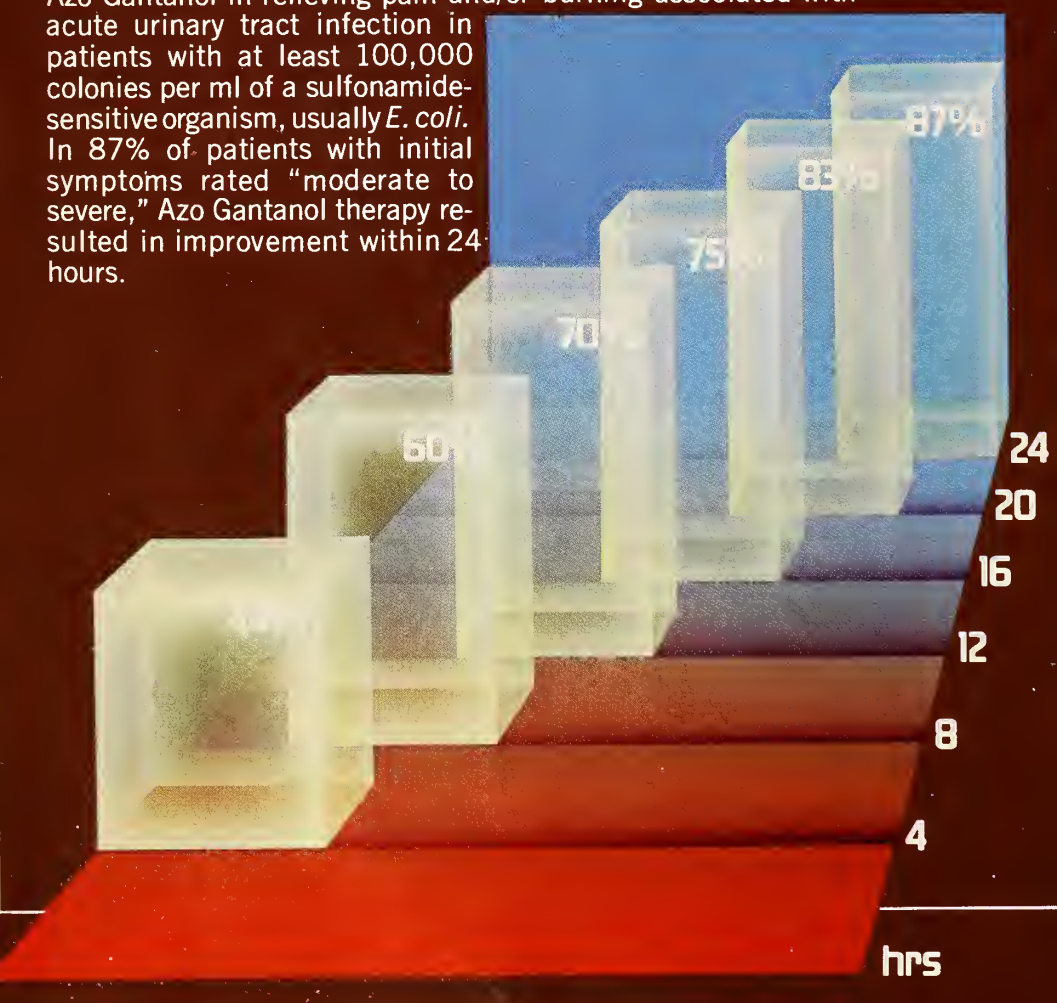
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ORAL SUSPENSION
Please see brief summary of prescribing information on facing page.
a drug of choice in pinworm infections
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Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli.* In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete pr uct information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organis (usually *E. coli, Klebsiella-Aerobacter, Staphyl coccus aureus, Proteus mirabilis,* and, less fre quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: C fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; aminobenzoic acid to follow-up culture media. increasing frequency of resistant organisms lin the usefulness of antibacterials including sul- fonamides.** Measure sulfonamide blood levels variations may occur; 20 mg/100 ml should b maximum total level.

Contraindications: Children below age 12; sul- fonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is cont dicated in glomerulonephritis, severe hepatiti uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not establi Deaths from hypersensitivity reactions, agranu tosis, aplastic anemia and other blood dyscra have been reported and early clinical signs (s throat, fever, pallor, purpura or jaundice) may dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are r ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with i paired renal or hepatic function, severe allerg bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria a stone formation.

Adverse Reactions: *Blood dyscrasias* (agran- ulocytosis, aplastic anemia, thrombocytopen leukopenia, hemolytic anemia, purpura, hypo thrombinemia and methemoglobinemia); *alle reactions* (erythema multiforme, skin eruptio Stevens-Johnson syndrome, epidermal necro urticaria, serum sickness, pruritus, exfoliativ dermatitis, anaphylactoid reactions, periorbi edema, conjunctival and scleral injection, ph sensitization, arthralgia and allergic myocard *G.I. reactions* (nausea, emesis, abdominal p hepatitis, diarrhea, anorexia, pancreatitis an stomatitis); *CNS reactions* (headache, peripl neuritis, mental depression, convulsions, ata hallucinations, tinnitus, vertigo and insomni *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarter nodosa and L. E. phenomenon). Due to cert chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral glycemic agents, sulfonamides have caused instances of goiter productlon, diuresis and glycemia. Cross-sensitivity with these agent exist.

Dosage: Azo Gantanol is intended for the a painful phase of urinary tract infections. *Us adult dosage:* 2 Gm (4 tabs) initially, then 1 (2 tabs) B.I.D. for up to 3 days. If pain pers causes other than infection should be soug After relief of pain has been obtained, cont treatment with Gantanol (sulfamethoxazole be considered.

NOTE: Patients should be told that the ora dye (phenazopyridine HCl) will color the uri

Supplied: Tablets, red, film-coated, each c ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 5

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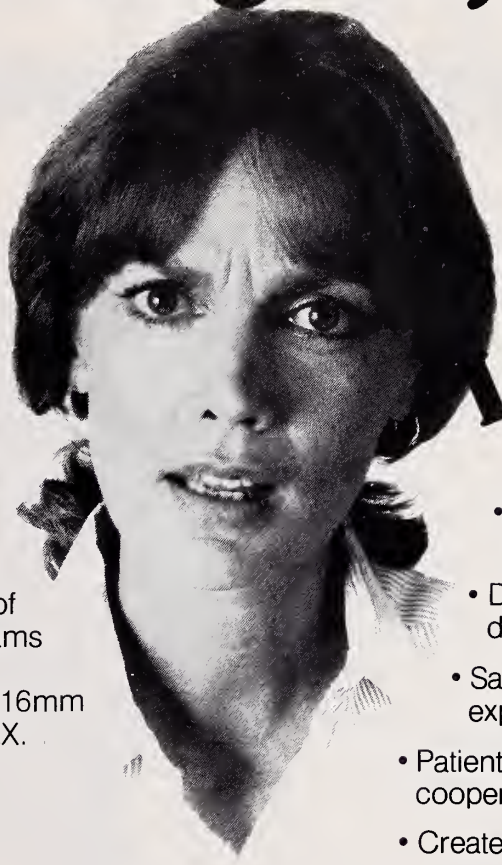
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for the pain **for the pathogens**

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

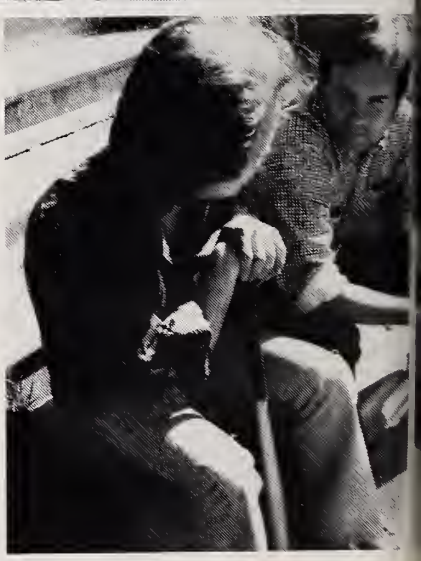
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addition are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge.



CHILDREN'S PROGRAM: To open October 1978 for ages 4-12.

Twenty-four hour admittance is offered for all programs.



STAFF:

BOAZ HARRIS, M.D., Medical Director
CONWAY HUNTER, JR., M.D., Director, Addictive Disease Unit
CHARLES D. STEWART, JR., M.D., Director, Adolescent Services
JOHN B. HARDMAN, M.D., Director, Children's Unit

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hat's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is separately accredited by the Joint Commission on the Accreditation of Hospitals.

plete information or a personal tour of the facilities and explanation of programs, contact:

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MEDICAL MEETING CALENDAR

MAY

25-26—*Atlanta;* **PLATELET AND GRANULOCYTE TRANSFUSION;** Category 1 Credit; Contact: Dr. A. J. Grindon, Director, Atlanta Regional Red Cross Blood Program, 1925 Monroe Dr., N.E., Atlanta 30324. PH: 404/874-1601.

26-27—*Atlanta;* **1978 AMERICAN SOCIETY FOR PARENTERAL AND ENTERAL NUTRITION SOUTHEASTERN REGIONAL SEMINAR: FUNDAMENTAL PRINCIPLES AND APPLICATION OF NUTRITIONAL SUPPORT—A TEAM CONCEPT;** Category 1 Credit; Contact: Department of Continuing Medical Education, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, ext. 2346.

31-June 3—*Winston-Salem, NC;* **NEUROLOGY FOR INTERNISTS AND FAMILY PHYSICIANS;** Category 1 Credit; Contact: Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

JUNE

1-2—*Atlanta;* **ESSENTIALS OF PRACTICE MANAGEMENT FOR THE CARDIOLOGIST; BUSINESS ESSENTIALS FOR THE CARDIOLOGY OFFICE MANAGER;** Contact: Duane M. Johnson, Ph.D., Practice Productivity Inc., 2000 Clearview Ave., Atlanta 30340. PH: 404/455-7344.

2-3—*Atlanta;* **ADVANCED ANATOMY, KINESIOLOGY, AND BIOMECHANICS OF THE HAND AS APPLIED TO CLINICAL PRACTICE;** Category 1 Credit; Contact: Division of Orthopaedic Surgery, Emory University School of Medicine, Atlanta 30322.

2-3—*Lexington, KY;* **FIBEROPTIC BRONCHOSCOPY;** Category 1 Credit; Contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

2-6—*Hilton Head, SC;* **SURGICAL REPAIR AND RECONSTRUCTION OF THE ATHLETE'S KNEE: DIAGNOSTIC ARTHROSCOPY AND ARTHROGRAPHY;** Category 1 Credit; Contact: American Academy of Orthopedic Surgeons, 430 North Michigan Ave., Chicago, IL 60611.

4-8—*Atlanta;* **MEETING, AMERICAN ASSOCIATION OF IMMUNOLOGISTS;** Contact: H. Metzgar, Secretary-Treasurer, 9605 Rockville Pike, Bethesda, MD 20014.

5-6—*Atlanta;* **ESSENTIALS OF PRACTICE MANAGEMENT FOR THE GASTROENTEROLOGIST; BUSINESS ESSENTIALS FOR THE GASTROENTEROLOGY OFFICE MANAGER;** Contact: Duane M. Johnson, Ph.D., Practice Productivity Inc., 2000 Clearview Ave., Atlanta 30340. PH: 404/455-7344.

6—*Atlanta;* **GROUP AND FAMILY THERAPY;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., N.E., Atlanta 30326.

8-9—*Atlanta;* **SECOND ANNUAL CONFERENCE ON PAIN: CHRONIC PAIN, DISABILITY, AND DRUG ABUSE;** Category 1 Credit; Contact: Steven F. Brena, M.D., Emory University School of Medicine, Atlanta 30322.

8-10—*Lexington, KY;* **ANNUAL WANGENSTEEN SURGICAL SYMPOSIUM;** Category 1 Credit; Contact: University of Kentucky College of Medicine, Office of Continuing Education, 800 Rose St., Lexington, KY 40506.

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13-18—*Gulf Shores, AL;* **ANNUAL MEETING, ALABAMA ACADEMY OF FAMILY PHYSICIANS;** Contact: Joyce T. Golden, Alabama Academy of Family Physicians, 19 South Jackson St., Montgomery, AL 36104. PH: 205/263-6441.

14-17—*Sea Island;* **THIRD ANNUAL SYMPOSIUM ON LUNG DISEASE;** Category 1 Credit; Contact: Gilbert D. Grossman, M.D., Emory University School of Medicine, Atlanta 30322.

15-17—*Jekyll Island;* **INTERNAL MEDICINE;** Category 1 Credit; Contact: Gerald T. Chambers, M.D., Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

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17-22—*St. Louis, MO;* **AMA ANNUAL MEETING;** Category 1 Credit; Contact: James H. Sammons, M.D., 535 North Dearborn St., Chicago, IL 60610.

19-20—*Atlanta;* **WHAT'S HAPPENING: NATIONAL CONFERENCE FOR TEENAGERS ON SEX, BIRTH CONTROL, TEENAGE PREGNANCY, AND OTHER HEALTH PROBLEMS OF TEENAGERS;** Contact: Family Planning Program, 69 Butler St., S.E., Atlanta 30303.

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29-July 1—*Hilton Head, SC;* **GENERAL PEDIATRICS;** Category 1 Credit; Contact: American Academy of Pediatrics, 1801 Hinman Ave., Evanston, IL 60201.

JULY

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Letters to the Editor . . .

Dear Sir:

As evidenced by Dr. Milton Johnson's comments in the March "President's Letter," the physician assistant concept *might* be considered by some as part of a government plot to destroy the "private quality medical care in this country." The views expressed by Dr. Johnson, however, do not accurately reflect the facts relating to the physician assistant profession. The physician assistant, as defined and accepted by the AMA, is a "skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

The implication that the physicians' assistant (PA) will work independent of the physician, on a fee-for-service basis, and in competition with primary care physicians indicates a basic lack of knowledge of what a physician assistant is, how (s)he is trained, certified and utilized. Each PA in Georgia is a dependent medical practitioner, certified by the Georgia State Composite Board of Medical Examiners to a specific physician employer who is responsible for and controls the actions of the physician assistant. The PA then functions under physician supervision, performing approved duties for which (s)he has been trained and certified as capable of performing.

One of the objectives of the Georgia Association of Physician Assistants (GAPA) is to inform the professional public of the training, certification, and utilization of physicians' assistants. The AMA definition "Statement on the Role of the Physicians' Assistant in Relation to the Licensed Physician" should help to clarify some of the misconceptions of the physician assistant as expressed by Dr. Johnson. Further information regarding physicians' assistants is available upon request by writing GAPA, P.O. Box 2037, Decatur, Ga. 30030.

Alan B. Sams, P.A.-C.
President
Georgia Association of Physicians' Assistants

Dear Sir:

I would like to bring to the attention of the physicians of Georgia that there is an almost unknown and, certainly seldom recognized, anomaly in the Georgia code of law that can place a physician sued for malpractice in double jeopardy. My present position serves as a case in point in regard to this anomaly of law.

Briefly speaking, I was sued for malpractice in September 1973. After the usual multiplicity of depositions and research of the literature on my part, a trial was begun in May of 1976. This was aborted one day later after the plantiff's counsel became dissatisfied with one of the jurors. The next trial did not begin until November, 1977.

With the onset of the new trial last November, I was appropriately anxious and nervous, but as the trial progressed I thought that we were able to present the facts to an intelligent jury in a logical fashion. Finally on a Friday afternoon (after beginning on Monday morning) the case was given to the jury. The jury was out for some eight hours and this caused me a great deal of panic, but later I learned they were going over the voluminous amount of evidence. About thirty minutes after reviewing the evidence in its entirety, the jury returned a verdict in my favor.

The ecstasy and glory of vindication was very short lived. Some two weeks after a jury of twelve intelligent and knowledgeable women and men returned a verdict in favor of the defense, the judge of the case overturned the verdict and ordered a new trial. The irony of this situation is even heightened by the fact the judge never examined any of the evidence, only listened to the testimony in the courtroom, which of course is biased on many occasions.

The crux of the judge's decision to overturn the verdict is pivotal in that if he gives a specific reason, then one may appeal this. However, if the judge orders a new trial on general reasons there rarely can be an appeal. In addition, this same presiding judge has to give approval for any appeal process.

At this time, I am now awaiting a new trial in May of this year. Hopefully, we can obtain a jury that will not be swayed by emotion, but will look only at the facts as did our last jury.

I hope by bringing out this little known aspect of the law, we might be able to bring about legislation to change this dictatorial right of judges who may be prejudiced for any number of reasons. After all, in this present situation, one man (the judge) can be both judge and jury.

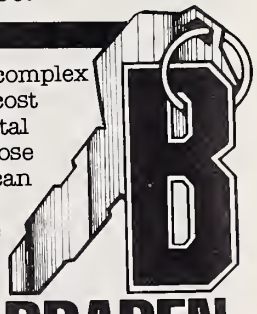
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Beclomethasone Dipropionate: A New and Valuable Tool in the Management of Severe Asthma

FRANK M. PICKENS, M.D. and P. BAILEY FRANCIS, M.D., *Atlanta**

CORTICOSTEROIDS HAVE BEEN USED in the treatment of severe asthma for more than 25 years; however, serious side effects are frequently associated with prolonged therapy. Well-known sideseffects include weight gain, osteoporosis, cataracts, and potential worsening of hypertension and diabetes mellitus. Beclomethasone dipropionate (Vanceril®, Schering Corp., Kenilworth, N.J. 07033), a synthetic corticosteroid, was released for use in the United States in 1976. Earlier reports from Great Britain indicated that this corticosteroid aerosol was effective in the treatment of steroid-dependent asthma, and in therapeutic doses did not produce the adverse systemic effects which often accompany orally administered corticosteroids.

Pharmacology

Beclomethasone dipropionate is a synthetic corticosteroid which is chemically similar to prednisolone. Animal studies have shown that the agent has potent anti-inflammatory activity. It also has a high topical anti-inflammatory effect on human skin, being five hundred times more potent than dexamethasone.[1] The enhanced topical activity probably results from esterification of the steroid moiety, making the molecule relatively lipid-soluble and water-insoluble.

Several studies have shown that the use of beclomethasone in doses of 400-800 micrograms daily does not affect adrenal-hypothalamic-pituitary function.[1-3] However, impairment of adrenal function has been documented at a dose of 1600 μg per day.[4] Additionally, Yernault et al.[5] found that 400 μg of aerosolized beclomethasone daily does not significantly alter glucose tolerance or plasma insulin levels.

Rapid absorption of beclomethasone occurs from both respiratory and gastrointestinal tissues. When administered as an aerosol, over 50 percent of the drug is swallowed after being deposited in the mouth and oropharynx. Beclomethasone is thought to control asthma without corticosteroid side effects because of its high topical activity and rapid inactivation of the drug in the liver.[1]

Although prolonged local application of corticosteroids to the skin may cause atrophy, electron and light microscopic examination of bronchial biopsies from patients using beclomethasone aerosol for up to 18 months have shown no significant abnormalities.[6, 7]

Clinical Use

Controlled studies have shown that beclomethasone is an effective alternative to the use of orally administered corticosteroids in the treatment of asthma.[2, 8] Many patients requiring 20 milligrams (mg) per day or less of prednisone for control of asthma can be transferred successfully to aerosolized beclomethasone.

The usual starting dose of beclomethasone is 400 μg (two inhalations four times daily). Doses up to 800 μg daily have been shown to be effective in patients taking more than 16 mg of prednisone daily.[9] In the steroid-dependent asthmatic, systemic corticosteroids must be gradually reduced. Initially, the aerosol should be combined with the patient's maintenance corticosteroid dose for one to two weeks. Thereafter, the systemic dose can be reduced 2.5 mg every one to two weeks as long as symptoms are controlled. Temporary increases in systemic corticosteroids may be required during exacerba-

* Dr. Pickens is a pulmonary fellow, Department of Medicine, Emory University School of Medicine. Dr. Francis is chief, pulmonary diseases, VA Hospital (Atlanta) and assistant professor of medicine, Emory University School of Medicine. Dr. Francis' address is VA Hospital, 1670 Clairmont Rd., Decatur, Ga. 30033.

tions of asthma. Conditions such as eczema, vasomotor rhinitis, nasal polyps, and arthralgia may worsen during systemic corticosteroid withdrawal.[10] Beclomethasone has not been shown to be of value in the treatment of acute exacerbations of asthma.

Hazards

Patients who have taken systemic corticosteroids for prolonged periods often have significant suppression of hypothalamic-pituitary-adrenal function. Deaths due to adrenal insufficiency have occurred in such patients who have been transferred to aerosol steroid therapy too rapidly. Return of normal adrenal function after discontinuing corticosteroids may take longer than six months.[11] Until normal adrenal function has returned, oral or parenteral corticosteroid replacement should be used during periods of stress.

The incidence of oropharyngeal colonization with *Candida albicans* in patients using beclomethasone is high—77% in one series.[9] However, oral candidiasis is often asymptomatic, self limited, and does not necessitate discontinuance of the drug. Symptomatic oral candidiasis is usually easily controlled with nystatin. This complication may possibly be prevented by having the patient rinse his mouth and gargle C saline or water following each series of inhalation.

Summary

The recent introduction of beclomethasone dipropionate has been a major development in the treatment of asthma. Daily doses up to 1600 mg do not suppress hypothalamic-pituitary-adrenal function. The primary indication for use of this inhaled steroid is in patients with asthma who would otherwise need systemic corticosteroid therapy. Use of corticosteroids should be considered only in the asthmatic who is inadequately controlled by optimal bronchodilator therapy and cromolyn sodium. The major potential problem associated with beclomethasone therapy is adrenal insufficiency in patients who have been on prolonged systemic corticosteroid therapy.

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Dr. Logue joined the faculty of the Emory School of Medicine in 1945 and has played an important role in the school's development. The founding president of the Georgia Heart Association, Dr. Logue is also one of the founders of the Emory University Clinic and established the first residency in cardiology at Grady Memorial Hospital.

He has held weekly teaching conferences at Grady Hospital for 32 years and holds a teaching conference in cardiovascular disease at Emory University Hospital daily for the training of cardiologists from the entire United States and Canada.

The establishment of the R. Bruce Logue Chair of Cardiology at Emory will enable the university to support a distinguished professor in the field of cardiology, a program of research to develop new and improved methods of treating heart disease, visiting lecturers in cardiology, and a course of teaching and training in the field.

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Some useful sight-saving hints from an expert in the field . . .

Eye Emergencies

THOMAS P. MANCHESTER, M.D., *Atlanta**

It is interesting to consider the possibility of how one might handle many eye emergencies over the telephone. For example, any one may have a call in regard to a patient who has just sprayed oven cleaner in her eye or some one may have just received an eyeful of battery acid. Chemical burns of the eye are potentially very serious and cannot be taken lightly. They should be irrigated immediately with water. The first five minutes are extremely important and what is done during this five-minute period is more vital than anything an ophthalmologist might do during the following several months. So one should tell the patient to leave the telephone and to wash the eye with copious amounts of water. We may tell him to fill the sink with water and to hold his face down in the water and pull his eyelids apart. Or he may run into the shower and turn the water on his face for ten minutes. Alkaline burns are five times as bad as acid burns, but water is still the safest treatment for either one. For example, oven cleaner, being alkaline, will probably produce a deeper, more permanent injury to the eye than will the battery acid.

One may receive a telephone call some night about an eye injury from a screwdriver, scissors or a tennis ball. If the vision is disturbed, if there is blood in front of the iris, or if the pupil is irregular, then it is obvious that serious harm has come to the eye and you can tell this to the patient. A general anesthetic may be necessary for repair of the eye injury, so the patient should have nothing to eat or drink. Everyone should be warned not to push and pull on the eyelids in trying to examine the eye. It takes very little pressure to force the vitreous out through a laceration. Tell them to put a patch over the eye and to keep the patient quiet on the way to the emergency room.

Another emergency call which is frequent is that connected with the symptom of flashes of light and floating spots before the vision. This nearly always indicates a detachment of the vitreous and it should be handled as an emergency. The patient must see an ophthalmologist, because the detached vitreous may pull a hole in the retina. You might warn your patient that he should not lie down or even lean his head back against the seat of the car as the detachment of the vitreous might be more likely to pull on the retina. So it is better for him to sit upright and to allow his neck to take the jolts.

Ocular migraine can often be diagnosed over the telephone. The patient sees jagged lines or sparkling dancing lights followed by visual field defects, either central or paracentral. A headache may or may not follow these symptoms. Somehow in women a headache is more likely to follow, but in men the visual symptoms usually predominate. The doctor should reassure this patient that he is not about to have a stroke. Further questioning may reveal that he had similar symptoms many years ago.

An entirely different matter is the case of Amaurosis Fugax in which the patient loses all light perception in one eye for five minutes, then it returns rapidly to normal. He is very likely to have a stroke, especially if there is numbness of the opposite arm or leg. It is more important that the internist see this patient right away, rather than the ophthalmologist, in order to look for insufficiency of the carotid artery on the side of the amaurosis. When this patient is examined for his imminent stroke, one should dilate the pupils and look for emboli in the retinal arterioles. Ophthalmodynamometry and oculo-

* 35 Collier Rd., NW, Atlanta, Ga. 30309. This paper was presented at a Piedmont Hospital symposium, "Practical Ophthalmology for the Non-Ophthalmologist," in November of 1977.

plathysmography can be done in the vascular laboratory which is under the direction of Dr. Levering Neely and Dr. Steven Barnett at Piedmont Hospital.

Now, Dr. Smith, what will you do if you receive a call some night in which the patient of yours has lost all light perception in one eye and it has not improved after as long as an hour or more and the patient and his family look to you for help in their distress? The first thing you do is to tell them frankly that the patient has probably had a kind of stroke in the eye, that there is an obstruction to the central artery and that he must be taken immediately to the emergency room of the hospital. The patient should massage the eye vigorously for 30 seconds and then stop for 30 seconds. He should alternate pressure and no pressure during the time that he is on the way to the hospital. Next you telephone the emergency room and say you have a man with an occlusion of the central retinal artery. Go ahead and start the treatment and get the ophthalmologist on call. Tell them to start oxygen and carbon dioxide breathing 95% oxygen, 5% carbon dioxide. Give the patient 500 mg of Diamox intravenously and continue the massage. You want to lower the ocular pressure and allow the embolus to pass further out in the vascular tree. Later, the ophthalmologist may do intravenous fluorescein studies, may do a paracentesis, inject vasodilators and look for glaucoma.

He will no doubt admit the patient to the hospital and you can go by to see him later when it will be your task to check the blood sedimentation rate and look for signs of temporal arteritis. Early treatment for temporal arteritis, as you know, may prevent the development of blindness in the second eye. You should look especially for carotid disease, hypertension, heart disease.

Another entity which can be diagnosed from the history is a flash burn. Often the pain is so severe that the patient may be very upset and you can help him greatly by reassuring him that there will be no permanent harm. This history will be that severe pain in the eyes has developed rapidly and it came five or six hours after exposure to an ultraviolet light such as a welding arc or a sunlamp. This is the same condition as snow blindness. The patient can be reassured that he will be well within 24 hours. *This is the only eye condition in which we might allow the patient to use topical anesthetic drops to get him through the night.*

If the patient calls about having developed a Bells Palsy, be sure to advise him to put a bland ointment in the eye every night and to use a protective lubricant in the eyes during the day. Ulceration from lagophthalmos can develop rapidly. A popular ointment for this is lacrilube.

Most of you will probably think of herpes zoster ophthalmicus when the patient has a deep boring pain on one side of his forehead and a vesicular rash with hyperesthesia. The eye symptoms are usually mild at first, but the point you must remember and warn the patient that ocular complications are often very severe and they do not appear until about the time that the rash is subsiding.

If your emergency call is in regard to a patient who is unconscious, be sure that his eyes are closed because serious harm will develop from corneal drying which causes ulceration. Always ask if the patient wears contact lenses. So many patients of all ages wear them nowadays and this should be thought of when anyone is unconscious. The contact lenses must be removed when the eyes are shut, because even an hour of wearing a contact lens with the closed eye can cause a large painful corneal abrasion.

To round out my discussion of ocular emergencies, I would like to remind you of the differential diagnosis of the red eye. This includes glaucoma, iritis, infection and subconjunctival hemorrhage. The glaucoma eye will have a dilated pupil and the eye with infection has normal vision, normal pupils and pus present and stuck to the eyelashes. If the patient has a bad cold and a sore throat at the same time as the eye infection, it is safe for you to prescribe antibiotic eye drops over the telephone, such as Chloroptic, but *never a cortisone antibiotic mixture* because he could have herpes simplex.

Cataracts

Now I will discuss another subject in which the internist's knowledge and advice to the patient is often very important. Certainly the subject of cataract surgery, e.g., when to operate and what technique to use, is very confusing at the present time and you can be a great help to the patient in reassuring him and being involved in the decision making. If you merely encourage the patient to see another ophthalmologist and get a second opinion, you may have helped greatly, since it is a serious decision for him and sometimes unnecessary surgery may be avoided. Conversely, a patient may need surgery when he was told that nothing could be done.

Alkaline burns, such as oven cleaner, are five times as bad as acid burns, producing a deeper, more permanent injury to the eye.

There are three popular methods for removing cataracts today. The freezing method is one in which the lens is removed in its entirety as a tiny iceball when it has been touched with a cryoprobe. A second method, phacoemulsification (as discussed by Dr. North) has had tremendous publicity and patients are

still demanding this type method of surgery on themselves. The third technique is a cataract extraction by either of the two methods plus the insertion of an intraocular lens.

Someone spoke on a television program recently of patients going to have their cataracts removed on their lunch hour. In answer to this, one might say that it is possible to have an appendectomy or maybe even a hypophysectomy during a lunch hour, too. Some patients have the mistaken impression that cataract surgery can be taken lightly. One answer to this might be that in the United States today, cataract surgery complications are not less than they were 15 years ago, but they are actually greater because so many new techniques are being tried with the patient taking the brunt of the experimentation instead of laboratory animals.

It is unfortunate that many patients are given the impression that a cataract should not be allowed to remain in an eye because by its very presence the eye may be hurt and go blind. Most people over 60 have some cataract but live out their lives without complications if left alone. It is true that glaucoma and iridocyclitis can result from a hypermature cataract. However, a cataract operation can still be done even if these complications develop and then the condition will be cured. These complications are extremely rare and they do not come frequently enough so that cataract surgery should be done to avoid them any more than appendectomy should be done to prevent the patient from later developing appendicitis.

The typical problem patient who needs help is the one who is old, discouraged, and depressed, who says "I feel bad all over, unsteady on my feet, I am going blind—nobody cares—why doesn't somebody do something for me. If only I could see better, then everything would be all right."

In my opinion, if the patient is old and feeble and has one good eye which sees 20/50 or better, then neither eye should have surgery. If he can still read or sew, then he will probably do no more than this even after a perfect surgical result; so why put him through an operation? Sometimes, merely a prescription for stronger glasses will allow the patient to read and to function normally. Occasionally a drop of a mydriatic in the eye will dilate the pupil enough so that the patient can see around the cataract and get along very well. With these old patients, I don't give them an outright no as they may feel that everything is hopeless. Instead, I tell them the cataracts are not ripe yet, really meaning that the situation is not ripe.

There are patients who are young enough and alert enough to be so active that binocular vision is needed. If their reflexes are quick so that they are safe at the wheel of a car, then they deserve a try at binocular vision and therefore, surgery is indicated for a cataract even though the vision is fairly good in the other eye. Binocular vision is important for sports and driving. This is a case in which one ophthalmologist may say do nothing but an operation is really indicated.

Because removal of a cataract means removal of the lens, the only way in which a patient can use the two eyes together post-operatively is by wearing a contact lens on one eye or by having an intraocular lens implanted to replace the one in which was removed. As a general rule, the same patient who is active and alert enough to drive a car and to indulge in a sport so that he requires binocular vision, this patient should be well coordinated enough to handle a contact lens. A standard cataract extraction followed by a contact lens is usually the safer procedure to do than a lens implantation which may increase the complication rate 10%. If the patient later has complications from the presence of a lens implant within the eye, it is extremely difficult to remove this implant without damaging the interior of the eye because the lens implant itself very quickly develops adhesions and becomes attached and stuck to the ciliary body and the vitreous and retina after it has been inserted. Removing it always hurts the ocular contents, often irreparably.

Two cases are presented, both of which required exploratory celiotomy.

Bacteroides Bacteremia Secondary To Occult Disease of the Gastrointestinal Tract

WILLIAM G. WHITAKER JR., M.D., RONALD KAPLAN, M.D. *and* MARK C. HUTTO, *Atlanta**

IT IS WELL KNOWN that many disorders in the gastrointestinal tract may be causes of prolonged fever.[1-3] Petersdorf and Beeson found that of one hundred cases of protracted fever of undetermined origin, twenty-four had as their cause a disease involving the digestive tract.[4] Viral hepatitis, tuberculosis of the liver, cholecystitis, cholangitis, pyogenic liver abscess, salmonella enteric infections, regional ileitis, perirectal abscess, diverticulitis of the colon, and various neoplasms of the bowel and liver have on occasion been identified as a cause of continuing fever. Obviously, in the majority of cases, some pertinent significant symptom or finding will lead to correct diagnosis.

It is indeed likely that patients with fever of undetermined origin secondary to gastrointestinal tract disease will on occasion be found to have bacteremia if routine blood cultures are part of the diagnostic protocol. Fever and bacteremia occurring in patients with minimal or no abdominal symptoms or positive findings may be encountered, and this group poses many problems in diagnosis and management. Bacteroides bacteremia is most often a surgical disease occurring in postoperative patients or those who have had some instrumentation, particularly of the genitourinary tract, but a similar picture is seen in patients not subjected to surgery or instrumentation. The majority of patients are those who have had an operation upon bowel or obstructed biliary tract which is normally rich in commensal bacteroides.[5] Bacteroides bacteremia in the nonsurgical patient who presents minimal localizing symptoms strongly suggests the GI tract as its source. Bacteroides bacteremia has many similarities with aerobic gram negative bacteremia except that jaundice, liver abscesses, and pylephlebitis are more common in the former.[6]

The cases reported here are those with clinically unsuspected bacteroides bacteremia in a setting of protracted fever with minimal abdominal symptoms and findings. Both patients required exploratory celiotomy and the ultimate diagnosis disclosed at operation was not strongly suspected preoperatively in either case.

Case No. 1

A 43-year-old, otherwise healthy, housewife, mother of three children, began having lower abdominal discomfort with nausea about eight days prior to admission. A diagnosis of pelvic inflammatory disease was suspected and she was placed on antibiotic therapy. About four days after the onset of her illness, she began having shaking chills with temperature elevations of 103-104° F. even though she was on large doses of intramuscular Penicillin. Her symptoms continued unabated and her antibiotic program was changed to oral Ampicillin. She was referred to Piedmont Hospital because nausea and vague lower abdominal discomfort and fever had persisted. The initial impression at the time of admission was a lower urinary tract infection which had been resistant to the antibiotics which she had been taking, but a normal urinalysis in addition to normal intravenous urography done at the time of admission mitigated this diagnosis. Films, however, taken at the time of intravenous pyelography did demonstrate a stone thought to be in the gallbladder. On admission, the abdomen was slightly tender and no signs of peritoneal irritation were present; no organ or other masses were palpable. Pelvic examination practically excluded inflammatory disease as a diagnostic probability.

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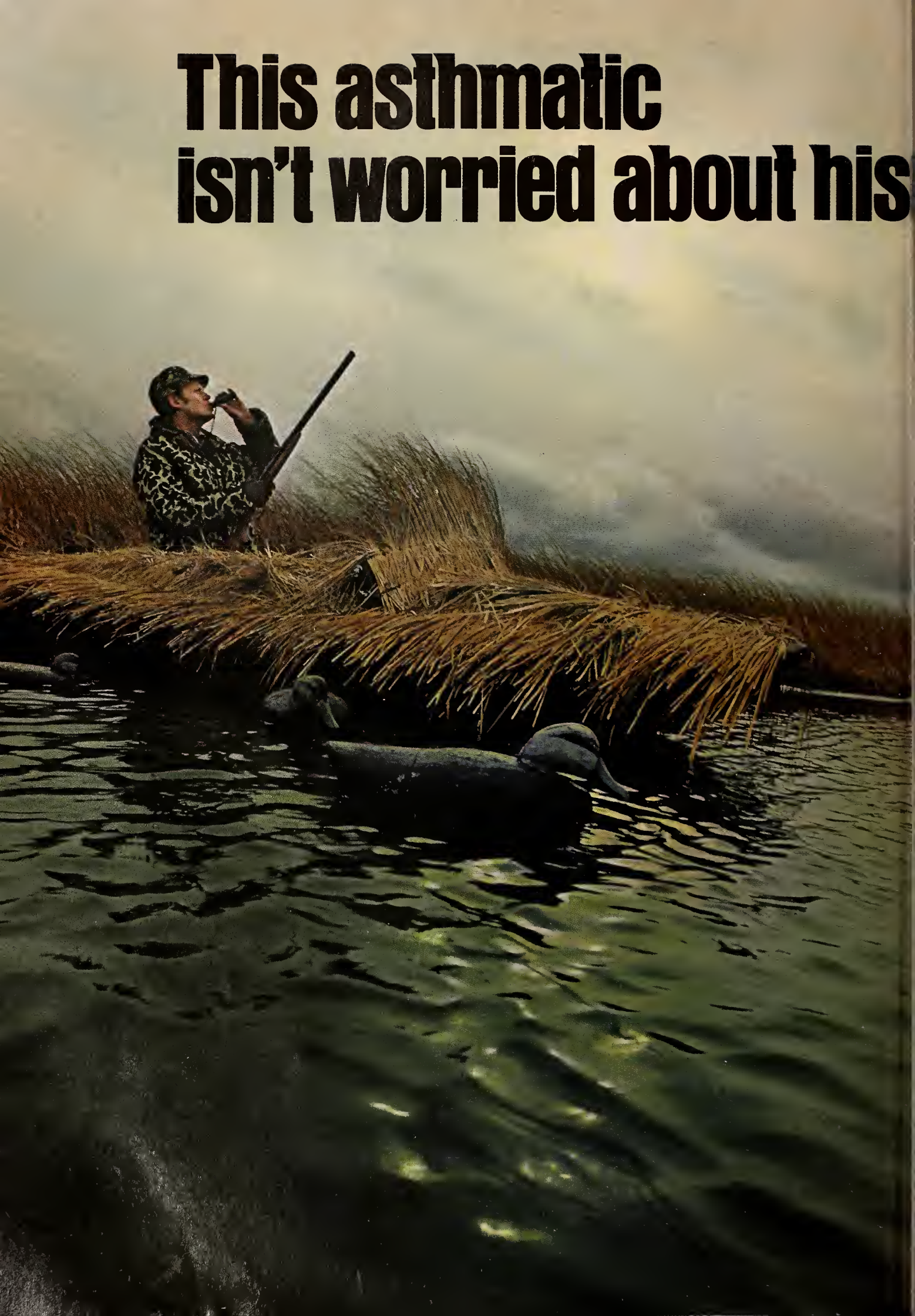
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Reference 1. Data on file. Mead Johnson Pharmaceutical Division.

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Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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Because of the presence of a stone presumably in the gallbladder, an intravenous cholangiogram was carried out which demonstrated a faint filling of the common bile duct but no visualization of the gallbladder. The following day an oral cholecystogram was equally unsuccessful in visualizing the gallbladder and at this point cholecystitis was suspected even in the absence of pain or tenderness in the area of this organ. Chemical analysis of the blood (SMA 18) demonstrated an elevation of alkaline phosphatase to 456 units, but all other studies were within normal limits. Her white blood count on admission was 8,500 with eighty-one percent polymorphonuclear leukocytes. She continued to spike a temperature up to 104° F. daily during the first three days of her hospitalization, during which time abdominal findings continued to be essentially negative. At this point all antibiotics were withdrawn because it was felt that a drug fever was a possibility and because another member of the family had had a somewhat similar clinical picture at the time. However, she did not improve on withdrawal of antibiotics and a blood sample drawn during the peak of temperature elevation subsequently was reported positive for bacteroides fragilis. She continued to have a spiking temperature with the white blood count rising to 22,000. Repeated roentgenograms of the chest and a computed tomography scan of the abdomen were within normal limits. A barium enema demonstrated a few diverticula of the sigmoid colon without any radiographic evidence of diverticulitis. Throughout her entire period of hospitalization, repeated abdominal examinations failed to disclose any clues as to the cause of her illness or its localization. When additional blood cultures revealed bacteroides fragilis, a focus in the gastrointestinal tract came under strong suspicion, with cholecystitis secondary to cholelithiasis and the presence of several diverticula in the sigmoid colon being the only positive findings.

On the seventh day of her admission (the fifteenth day of her present illness) she was taken to the operating room for exploratory laparotomy, with the gallbladder being the most likelystarget, although there continued to be an impressive lack of tenderness in the right upper abdominal quadrant. At operation the gallbladder was found to harbour one freely movable stone, but there was no evidence whatsoever of any inflammatory process. A mass was felt in the lower abdomen. This proved to be an inflammed segment of the sigmoid colon (acute diverticulitis) with perforation into the leaves of its mesentery overlying the promontory of the sacrum. The involved area of sigmoid colon with its mesentery, which included a small abscess, was resected and bowel continuity restored by end-to-end anastomosis. The bowel had not been prepared with antimicrobial drugs but had been mechanically cleansed. She withstood the procedure well and was dismissed from the hospital improved and afebrile on the ninth postoperative day and has remained well since that time.

Case No. 2

A 30-year-old banker was first admitted in September 1974 complaining of an abrupt onset of chills, fever, malaise, and discomfort in the upper right abdomen. Two months prior to this admission, he had a similar episode which was thought to be pyelonephritis, was treated with oral Cephalothin to which he responded promptly and had no further problems until the present admission. At the onset of his illness while an outpatient, tenderness in the right upper quadrant supported cholecystitis as a probable diagnosis and an intravenous cholangiogram failed to opacify either the ducts or the gallbladder, giving further credence to this diagnosis. Urinalysis and intravenous urography were negative and the white blood count was 15,400 with 85 percent segmented leukocytes. General physical examination revealed no significant finding other than vague tenderness in the right upper abdominal quadrant. Roentgenograms of the chest were negative and oral cystograms revealed suboptimal opacification of the gallbladder without stones. Technetium liver scan revealed no abnormality, and repeated blood cultures failed to demonstrate bacteremia. Blood chemistry (SMA 18) disclosed a very slight elevation of serum bilirubin to 1.2 milligrams percent; otherwise, all studies were within normal limits. Little response was noted following therapy with Gentamycin and Cephalothin, but some decline in daily temperature spikes appeared to relate with oral Cephalexin therapy and he was dismissed improved on the tenth day of admission.

Undisclosed intra-abdominal inflammation was strongly suspected as a cause of his problem. The patient remained symptom free for ten weeks when he abruptly had chills, fever, and malaise almost identical to his previous illness, except no abdominal discomfort was present at this time. Because intraabdominal (gastrointestinal) inflammation was strongly suspected, an intensive diagnostic search was commenced in an effort to locate the focus of infection. Infusion nephrotomography, cholecystography, upper gastrointestinal series, barium enema, and hypotonic barium duodenography were all within normal limits as was a repeat liver Technetium scan. During the time required for the diagnostic procedures, his temperature fluctuated from 103° F. to normal and a clinical response to therapy of combined Clindamycin and Gentamycin was noted. However, blood cultures now revealed the presence of bacteroides fragilis. At this point,

surgical exploration was planned, considering the gastrointestinal tract as the most likely source of the bacteremia, although there were still no abdominal physical findings that would afford a lead to its localization. At operation, an inflammed retrocolic appendix containing an intraluminal abscess in its distal third was found and removed, following which the patient recovered and has remained well.

Comments

These cases illustrate the paucity of symptoms and physical findings which may be related with significant and severe inflammatory diseases of the gastrointestinal tract. Some element of pylephlebitis must undoubtedly be present to allow seeding of the bloodstream with pathogenic commensal organisms. Possibly the early use of broadspectrum antibiotics in such instances may have prevented frank pylephlebitis, multiple liver abscesses, and/or septic shock. Bacteremia of this type is more often seen in elderly patients and the morbidity and mortality are directly proportional to increasing age. Both cases presented here were in relatively young age groups, a fact that added further confusion and difficulty in establishing an early diagnosis. Both cases were found to have clinically unsuspected bacteroides bacteremia in a setting of minimal symptoms and findings. Each required exploratory celiotomy and the ultimate diagnosis disclosed at operation was one not strongly suspected preoperatively.

Summary

Occult disease of the gastrointestinal tract may be a cause of prolonged fever and bacteremia. The presence of bacteroides bacteremia in an otherwise asymptomatic patient strongly suggests the gastrointestinal tract as its source. Two case histories are presented which required exploratory celiotomy revealing clinically unsuspected appendicitis and sigmoid diverticulitis respectively as the cause of fever and bacteroides bacteremia.

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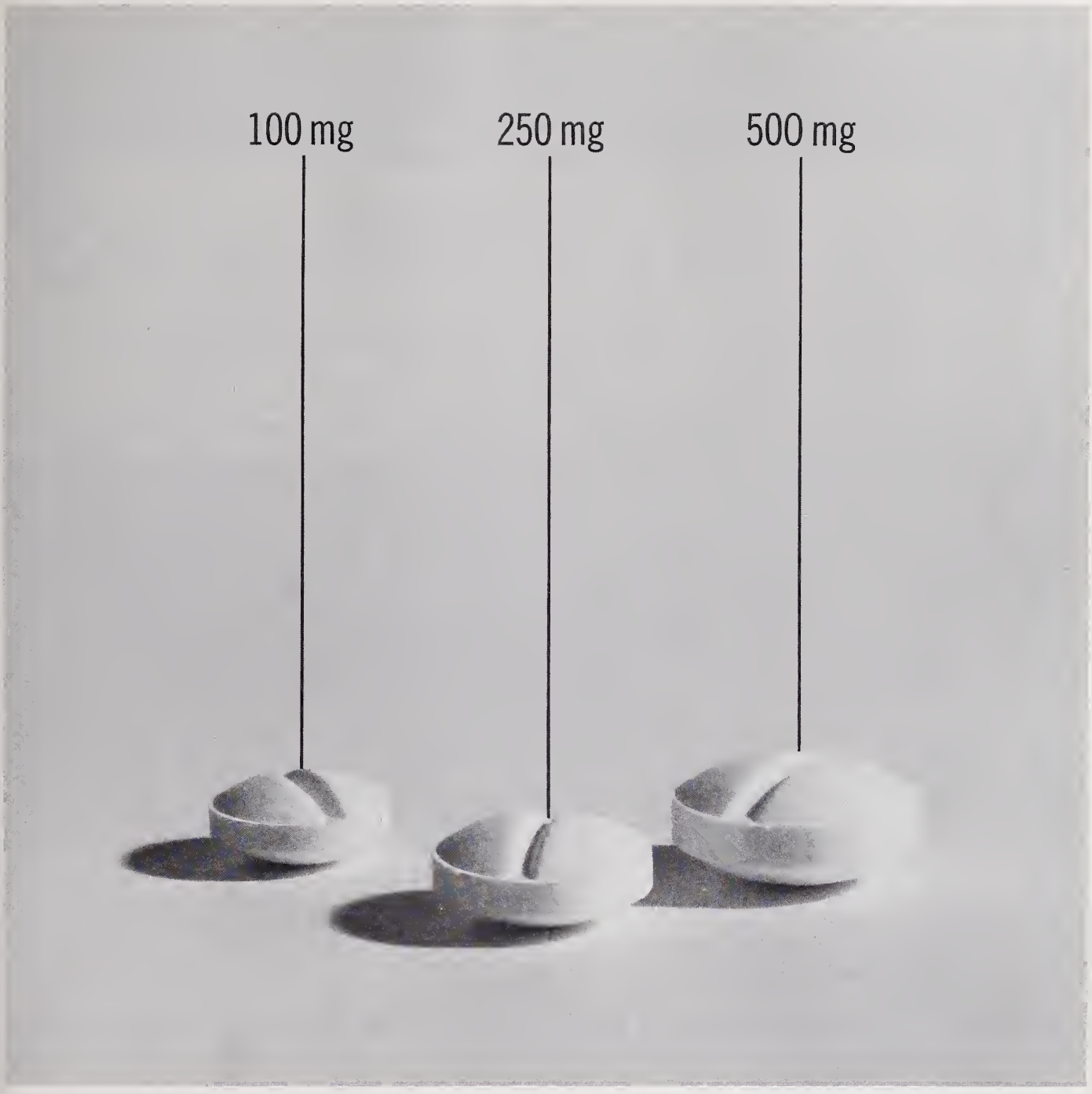
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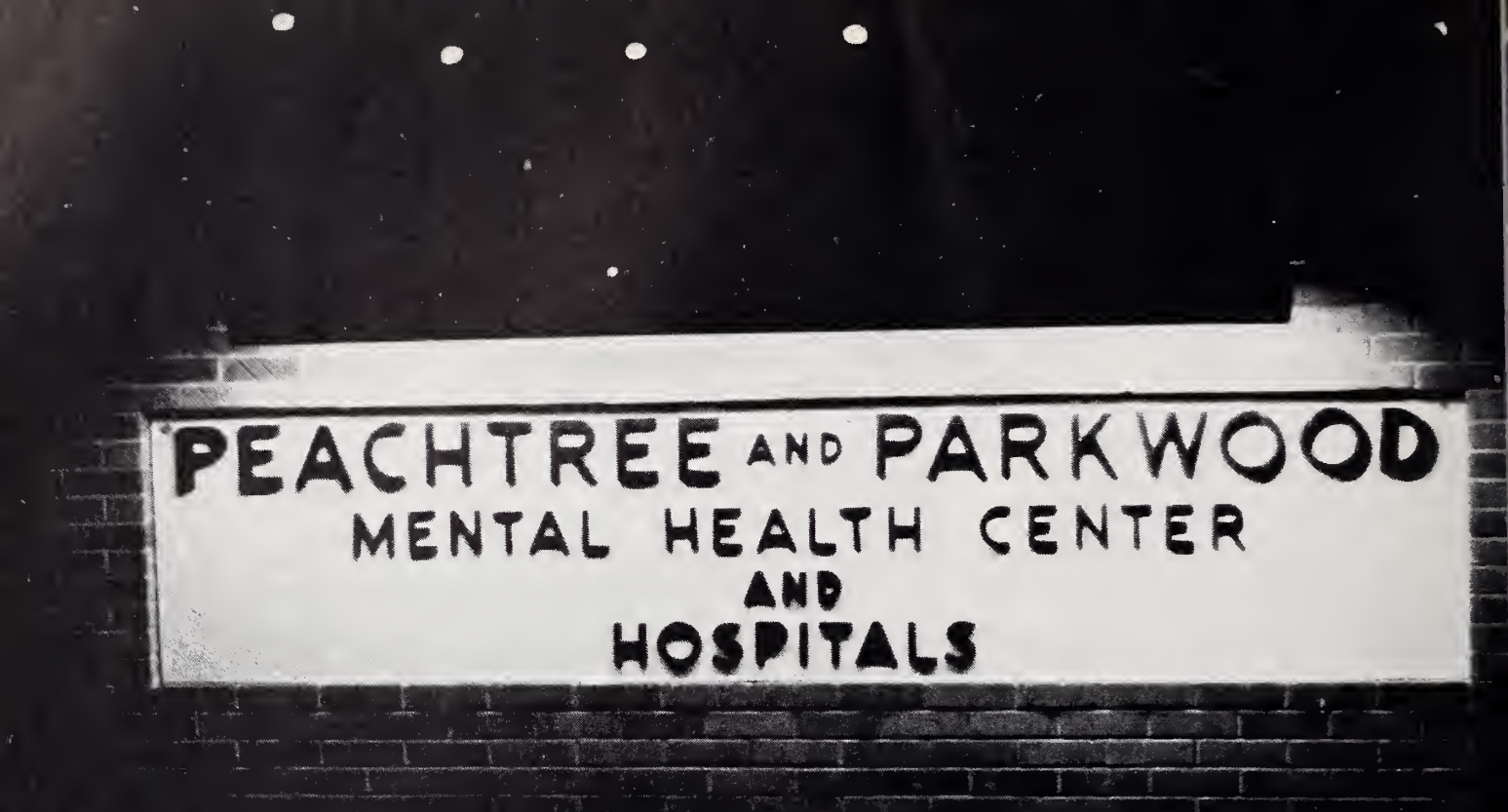
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While severe disease in almost any joint of the body may produce disability, the knee certainly ranks high on the list of joints producing disability severe enough to prevent employment. Therapeutic attack on the disease in the knee during the last two decades has included the injection of intra-articular substances in an effort to stop or retard the inflammatory process. These have included such things as nitrogen mustard, Thiotepa, osmic acid, corticosteroids, and radioactive gold and radioactive yttrium. Surgical synovectomy of the knee has been shown to reduce the pain and inflammatory process in the knee for a period of several years,[1] but no significant reduction in the extent of joint damage was demonstrated.

Since the initial report of Ansell[2] in 1963, irradiation of inflamed synovia by intra-articular radioactive substances has been reported to give good results in a majority of the joints treated. More than 1,000 patients have now been treated with radioactive gold or radioactive yttrium in Israel, England, and Europe, and, at the end of one year, approximately one-third had excellent results, one-third good results, and one-third little or no benefit. Delbarre[3] employed a double blind technique in the evaluation of 146 knees using yttrium-90, yttrium-89 (non-radioactive), and saline. After six months the results were considered excellent in 18%, good in 36%, and fair in 22%. No major complications and no long term deleterious effects have been reported with the use of radioactive yttrium-90 in the knee.

No product of yttrium-90 for intra-articular use is commercially available in the United States and the manufacturers in England and France have declined to make their preparations available in this country. Since the method of treatment offers a significant advantage over surgical synovectomy, manufacture of yttrium-90 hydroxide was undertaken at the Frank H. Neely Nuclear Research Center of the Georgia

* 993 Johnson Ferry Rd., NE, Atlanta, Ga. 30342.

Institute of Technology. Yttrium-90 is eluted from a strontium-90 cation exchange resin generator with citric acid solution and the yttrium citrate complex processed further to yttrium hydroxide at ph 7. This colloid is essentially insoluble in body fluids with less than 1% passing through a 4.5 micron filter. The average particle size as determined by electron microscopy is 25 microns.

Yttrium is non-toxic and essentially inert chemically. Yttrium-90 has a high energy beta radiation (2.25 MeV) with a half-life of 2.67 days. There is no gamma radiation. The beta radiation has an average soft tissue penetration of 3 mm and a maximum range of 11 mm, with 90% of the radiant energy being absorbed within 5.66 mm of a point source. The product therefore seems ideally suited for injection into a lined body cavity with the expectation that it will remain there until a major portion of the radiant energy has been dissipated by decay.

Animal Studies

A total of 55 rabbits were used in the evaluation of yttrium hydroxide in knee joints. Serial studies of yttrium-90 in the blood of 27 rabbits following intra-articular injection revealed no accumulation (Table I). Metabolic cages were used for collection of all excrement from eight rabbits for a period of seven to 11 days and the yttrium-90 excreted amounted to 0.032-0.236% of the intra-articular dose (Table II). Distribution of yttrium-90 to the liver, spleen, kidneys, muscles, and bone marrow revealed extremely small quantities (Table II) but the technical problem of self-absorption resulted in unreliable results, so an identical preparation of yttrium hydroxide was made with yttrium-88 ($88Y(OH)_3$), an isotope which emits gamma rays sufficiently strong for very accurate counting.

TABLE I

^{90}Y IN BLOOD STREAM AT INTERVALS FOLLOWING INJECTION INTRA-ARTICULARLY EXPRESSED AS PERCENTAGE OF TOTAL INJECTED*

	Days After Intra-Articular Injection				
Rabbit	1	4	5	6	7
1		.0044			
2		.0013			
3		.0014			
4		†			
5		.0018			
6		.0007			
7		†			
8	.0010				
9	.0026				
10		.0018			
11		.0007			
12		.0024			
13	.0002				
14	.0001				
15	.0002				
16	.0007				
17	.0010				
18				.0050	
19				.0060	
20	.0011	.0005			
21	.0008	.0025			
22	.0012	.0004			
23	.0006	.0002			
24	.00003		.0006		.0002
25	.0003		.0013		.0004
26	.0004		†		.0005
27	.0003		†		.0003

* Corrected for decay to time of injection.
† Counts on sample less than background.

Studies With Yttrium-88

Seven days following the injection of 16 microcuries of $88Y(OH)_3$ into the normal knee joints of eight rabbits, the total radioactivity was calculated for the injected knee, the remaining tissues of the injected extremity, muscle from the opposite extremity, bone marrow, liver, spleen, and kidneys. Eighty-seven to 100% of the injected yttrium remained in the joint of seven animals at the end of seven days and the average amount retained in the liver was 0.0177% and in the kidneys 0.0087%. (Significant leakage was observed at the time of injection in one rabbit.) (Table III.)

Because it has been shown that an inflamed joint has a more rapid leakage of injected material, an inflammatory reaction was produced in the knees of five rabbits using 2.5% suspension of bovine fibrinogen. Sections of the synovium revealed a chronic synovitis with lymphocytic and plasmocytic infiltrate predominating. One week following the injection of yttrium-88 hydroxide, 84 to 100% of the radioactivity was present in the inflamed joints (Table IV). The radioactivity in the joint and that in the remainder of the extremity accounted for 92.5 to 100% of the injected dose. Insignificant amounts were detected in other tissues, including 0.0172% in the liver and 0.0137% in the kidney.

Human Studies

Approval of the Food and Drug Administration for the study of this preparation of yttrium-90 hydroxide in human subjects with inflammatory joint disease in the knees was obtained. Testing for sterility and pyrogens as well as the final processing and shipment of the material is done by The Medical Research Foundation, Inc.

Methods

One week prior to admission to the hospital, the most inflamed knee was aspirated until free of effusion and 40 mg Triamcinolone Diacetate was injected to suppress inflammation. Using sterile technique 30 ml of normal saline was injected into the knee using a 22 gauge needle, 5 mCi of yttrium-90 hydroxide suspension in approximately 5 ml of dis-

TABLE II

Rabbit Number	mCi ^{90}Y Inj.	Days From Injection to Sacrifice	Remaining ^{90}Y in Tissue and Excreta* % of Total Injected in Total Organ Liver	Kidney	Excreta	Lung	Spleen	Muscle	mCi/Gram Tissue Rib	Vertebra	Colon	% Remaining in Joint of Amt. Inj. per Joint
18	224	6	1×10^{-6}	.0043		1×10^{-6}	1×10^{-6}	1×10^{-6}	5.5×10^{-5}	7.6×10^{-6}	1×10^{-6}	91.8
19	224	6	.160	.0017		.0058	.0034	5.3×10^{-5}	5.2×10^{-5}	25×10^{-5}	1×10^{-6}	67.8
20	864	11	.530	.0125	.057				.0048			45.6
21	864	11	.724	.013	.028				.0143			74.1
22†	864	11	.844	.138	.032				.0104			3.98
23	864	11	.370	.100	.236							36.2
24	890	7	.039	.0411	.033			.158	.0084			26.2
25	890	7	.145	.0377	.032			.084	.0016			39.9
26	890	7	1.250	.0661	.044			.039	.0014			38.7
27	890	7	.185	.0577	.099			.012	.0008			38.8

* Corrected for decay to time of injection.
† Leakage from joint observed.

TABLE III

DISTRIBUTION OF ^{88}Y IN NORMAL RABBIT JOINTS

Rabbit Number	Kidney	Liver	Muscle of Opposite Leg	Bone Marrow	Spleen	Remainder of Injected Leg	Injected Joint	Joint Plus Remainder of Leg
43	0.012	0.02	.0002	.0002	.0009		88.8	88.8
44	0.005	0.01	.0002	.0002	.0002	19.5	53.4	72.9
45	0.018	0.056	.0002	.0002	.0015		89.2	89.2
46	0.004	0.006	.0002	.0002	.0002	2.33	92.3	94.6
47	0.003	0.008	.0002	.0002	.0002	0.07	94.1	94.2
48	0.003	0.016	.0002	.0002	.0004	0.79	86.8	87.6
49	0.003	0.014	.0002	.0002	.0004	0.72	100.0	100.7
50	0.003	0.013	.0002	.0002	.0002	0.66	92.9	93.6

TABLE IV

DISTRIBUTION OF ^{88}Y IN INFLAMMED RABBIT JOINTS

Rabbit Number	Kidney	Liver	Muscle of Opposite Leg	Bone Marrow	Spleen	Remainder of Injected Leg	Injected Joint	Joint Plus Remainder of Leg
51	0.012	0.022	.0002	.0002	.0006	0.007	100.0	100.0
52	0.019	0.014	.0002	.0002	.0006	8.07	84.4	92.5
53	0.024	0.021	.0002	.0002	.0006	4.80	88.6	93.4
54	0.004	0.016	.0002	.0002	.0004	0.07	99.1	99.2
55	0.010	0.016	.0002	.0002	.0003	4.85	88.8	93.7

tilled water was injected through the same needle and the needle was then flushed with 3 ml of normal saline. An ultrasonic shaker was used to suspend the yttrium hydroxide. The needle was then withdrawn without removing the syringe and pressure was applied to the injection site for five minutes. The knee was then passively exercised through a full range of motion, both flexion-extension and rotation for several repetitions to insure dissemination of the yttrium hydroxide throughout the joint space. The Bremsstrahlung was then counted over the anterior, posterior, medial, and lateral aspects of the knee. A Picker Spectroscaler IIIA decode scaler at a distance of 17.5 cm was used without a filter, HV422 PhA 50-150 window in. Counts were then obtained over the inguinal-femoral lymph nodes, spleen, sternum, and liver with the collimator touching the skin. The knee was then splinted in approximately 15° of flexion using a long posterior plaster shell. Radioactive counts were obtained at 24 hours and at seven days over the same ports. Scans of the knees were also obtained at approximately one hour, 24 hours, and seven days following injection to demonstrate the uniformity of distribution within the knee. Urine and feces were collected for 72 hours, the splint removed and the patient dismissed from the hospital.

TABLE V

^{90}Y EXCRETION IN 72 HOURS[1] AFTER INJECTION IN ONE KNEE—R. A. PATIENTS

Patient	Amount Injected mCi	Urine		Feces		Total Excretion (Urine and Feces)	
		μCi	% of Exc.	μCi	% of Exc.	μCi	% of Inj. Dose
TRB	5.05	15.62	84.00	2.97	16	18.6	0.37
LMV	5.00	0.74	94.94	0.039	5.06	0.78	0.015
RTC	5.00	2.36	91.06	0.26	9.94	2.6	0.052
TLR	5.00	2.28	88.04	0.303	11.96	2.53	0.05
CLB	5.00	3.85	59.23[2]	2.65	40.77[2]	6.5	0.13
Total	25.05	24.85	80.00	6.22	20	31.01	0.123

1. CLB feces only 48 hours post-injection.
2. Urine and feces mixed to unknown degree.

Results

Very small amounts of radioactivity were excreted in the urine and feces during the 72 hours following injeczion of the yttrium hydroxide into the knee. Table V shows the breakdown for the five patients with 84-95% of the radioactivity being present in the urine and 5-16% in the feces. The average amount excreted was 0.123% of that injected.

Table VI shows the total counts per minute obtained from all ports of the knees. Since there is a great discrepancy between the counts obtained from a water phantom and those from the knees it is felt that each knee can best serve as its own control. Therefore, the ratio of counts per minute immediately following injection, at 24 hours, and at seven days are felt to reflect any loss of the radioactive yttrium from the joint. Subject TRB was the first patient studied and the technique for counting the knee was different in that the collimator was adjacent to the skin. Ninety-seven to 106% of the radioactive material remained in the knee at seven days, sufficient time for the radioactivity to have decayed to less than 18%.

Distribution to the regional lymph nodes, spleen, sternum, and liver is shown in Tables VII-X. When initially counted within one hour of the time of injection, the regional nodes showed radioactivity equivalent to approximately 25 times the room background count. This then doubled in the next 24 hours and then doubled again over the next 6 days. The spleen, sternum, and liver also showed rapid uptake, the increment being less than 100% of background in the first 24 hours. When expressed in terms of room background (which was not deducted from the counts shown), the liver and spleen demonstrated approximately 13 times the background radiation at the end of one week and sternum approximately 10 times.

Conclusion

(1) Yttrium-90 hydroxide demonstrated excellent retention in the rheumatoid knee under the conditions of this study.

(2) Extremely small amounts are excreted in the urine and feces during the first 72 hours following intra-articular injection.

(3) Dissemination to the regional lymph nodes occurred early and represents a small fraction of the amount injected.

(4) Dissemination to the spleen, sternum, and liver was also noted within one hour of injection. At the end of one week, the total radioactivity detected over the sternum was approximately 10 times and over the liver and spleen approximately 13 times the room background radiation.

(5) Evaluation of the clinical response to treatment with intra-articular yttrium-90 in these five patients will be reported at a later date.

Acknowledgement–This study was supported in part by grants from (1) Northside Medical Research and Educational Institute, Incorporated, Mr. Roland P. Smith, Registered Agent, 3151 Maple Drive, N.E., Atlanta, Georgia 30305, (2) Georgia Chapter, The Arthritis Foundation, 2799 Delk Road, S.E., Marietta, Georgia 30067.

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TABLE VI

COUNTS PER MINUTE TOTAL ALL PORTS FOLLOWING ^{90}Y $(OH)_3$ INJECTION IN KNEE

	1 Hour	24 Hour	24 Hr./1 Hr.	168 Hour	168 Hr./1 Hr.	168 Hr./24 Hr.
TRB	1,231,850	1,373,342	111.5	1,266,098	102.8	92.19
LMV	553,851	570,763	103.1	590,383	106.6	103.4
RTC	511,725	514,127	100.5	526,550	102.9	102.4
TLR	521,865	513,815	98.46	533,218	102.2	103.8
CLB	470,446	470,745	100.1	458,398	97.44	97.38

TABLE VII

REGIONAL NODES COUNTS PER MINUTE (Corrected) 250-350 CM. ROOM BACKGROUND

	1 Hour	24 Hours	168 Hours	168 Hr./1 Hr.	168 r./24 Hr.
TRB	3,511	11,220	15,356	4.37	1.368
LMV	987	1,173	2,819	2.86	2.403
RTC	868	1,084	2,888	3.33	2.664
TLR	1,630	2,926	8,250	5.06	2.819
CLB	751	1,018	4,624	6.16	4.542
Totals	7,747	17,421	33,937	4.38	2.063

TABLE VIII

SPLEEN COUNTS PER MINUTE (CORRECTED) 250-350 CM. ROOM BACKGROUND

	1 Hour	24 Hours	168 Hours	168 Hr./1 Hr.	168 Hr./24 Hr.
TRB	407	1,596	3,450	8.48	2.16
LMV	546	712	2,372	4.34	3.33
RTC	492	709	3,248	6.60	4.58
TLR	511	708	3,779	7.39	5.33
CLB	495	559	6,587	13.31	11.78
Totals	2,451	4,284	19,436	7.93	4.54

TABLE IX

STERNUM COUNTS PER MINUTE (CORRECTED) 250-350 CM. ROOM BACKGROUND

	1 Hour	24 Hours	168 Hours	168 Hr./1 Hr.	168 Hr./24 Hr.
TRB	591	1,100	3,568	6.04	3.24
LMV	457	638	2,366	5.18	3.71
RTC	440	780	3,490	7.93	5.97
TLR	531	585	3,286	6.19	5.62
CLB	445	539	2,418	5.43	4.49
Totals	2,464	3,642	15,128	6.14	4.15

TABLE X

LIVER COUNTS PER MINUTE (CORRECTED) 250-350 CM. ROOM BACKGROUND

	1 Hour	24 Hours	168 Hours	168 Hr./1 Hr.	168 Hr./24 Hr.
TRB	1,366	2,117	4,556	3.36	2.152
LMV	569	682	2,652	4.66	3.888
RTC	536	1,045	4,621	8.62	4.422
TLR	520	746	3,929	7.56	5.267
CLB	426	774	3,582	8.41	4.628
Totals	3,417	5,346	19,340	5.66	3.606

What Will Be the Impact of the Loss Of Foreign Medical Graduates On Georgia Hospitals?

GEORGE R. WREN, PH.D., EL MAHDI ALAMIN, SULAIMAN AL-BASSAM and HELEN COSTELLO, *Atlanta**

ONE OF THE PROVISIONS of Public Law 94-489 will require foreign medical graduates (FMGs) to take both parts of the National Boards or a specially designed H.E.W. test (the Visa Qualifying Exam of the NationalsBoard Of Medical Examiners) in order to qualify for admission to the United States and a preferred immigrant status. Previously, FMGs were only required to pass the ECFMG exam.

It is predicted that this new public law will result in drastic reduction of FMGs admitted to the United States to the point of practically nil.

There is no doubt that the intent is to stop the flow of FMGs to the United States, even though they constitute a large percent of interns and residents in the United States, not to mention the very large number of FMGs serving hospitals on a salaried basis as house physicians, emergency room physicians, licensed physicians in private practice, and others.

Why did Congress pass this part of the law? Undoubtedly, because of the criticisms levied against the influx of FMGs into the United States; because of questions concerning the quality of medical care provided by these FMGs; and because of the international political ramifications of this medical "brain drain"—the draining off by the United States of one of the scarce resources of the developing countries—their physicians.

This law was intended to be implemented on July 1, 1977, but due to objections of numerous organizations, including the American Hospital Association who pointed out that most internship, residencies and employment contracts for 1977-78 had already been signed, a moratorium was imposed on the implementation of this section of the PL 94-489. It went into effect January 10, 1978.

The Research Study

In order to investigate the impact on Georgia of PL 94-489, which will essentially eliminate the entry of foreign medical graduates into the United States, a team of undergraduate health administration students at Georgia State University and their faculty research director decided to undertake a study to seek an answer to that question. Questionnaires were mailed to the thirty-one Georgia hospitals known to have employed FMGs in 1973 or located in Georgia counties where FMGs were previously known to have been employed. These questionnaires were designed to collect data regarding numbers of FMGs employed, their job titles and roles, whether or not they were licensed in Georgia, what would be the effect of future non-availability of FMGs to hospitals, what the hospitals will do if FMGs are no longer available, and what other comments the respondents would wish to make on the subject.

The loss of these graduates will have a serious effect on state hospitals within Georgia.

For the purpose of this study, a foreign medical graduate was defined as "a physician who was a foreign citizen at the time he or she obtained his or her medical education in a foreign medical school." U.S. citizens obtaining their medical education in a foreign medical school were not defined as FMGs; neither were graduates of Canadian medical schools. Replies to the questionnaire were received from all thirty-one hospitals, either as an initial response or by telephone query.

This study only covered FMGs employed on a salaried basis by the hospital. Not included were foreign medical graduates in private practice in Georgia. Certainly these physicians are providing important medical care to the citizens of Georgia and their ranks will gradually be thinned with the implementation of PL 94-489. But that is another story which may be researched by the Institute of Health Administration at Georgia State University at a later date.

* Dr. Wren is director of the Institute of Health Administration, Georgia State University, University Plaza, Atlanta, Ga. 30303. His co-authors are undergraduate health administration students at Georgia State University.

The results of the research project.

Questionnaires sent out	31
Questionnaires returned	27
Replies received by phone	4
Total response (100% response)	31
Number of hospitals in study employing FMGs on a salaried basis	12
Number of hospitals in study employing FMGs not on a salaried basis	19
Total number of FMGs employed in Georgia in study hospitals	233
FMGs with a Georgia Medical License	117

Positions of FMGs in study:

	In State Psychiatric Hospitals	In Non-State Hospitals	Total
Interns	0	11	11
Residents	1	72	73
Salaried staff	114	32	146
Other (fellows)	0	3	3
Total	115	118	233
With Georgia Medical License	68	49	117
Without Georgia Medical License	47	69	116

FMGs Employed on a Salary Basis in Georgia Hospitals, August, 1977

	State Mental Hospitals–6	Other Georgia Hospitals–6	Total –12
Interns	0	11	11
Residents	1	72	73
Salaried staff physicians	114	32	146
Others	0	3 (Fellows)	3
Total	115	118	233
Number with Georgia Medical License	68	49	117

Comments From FMG Survey

I. In answer to the question "If you are unable to fill positions in the future with foreign medical graduates, which elements of health care delivery would be affected at your hospital?"

A. Answers from state psychiatric hospitals:

"Total operation."

"All psychiatric and medical."

"All in general."

"All."

"All psychiatric treatment."

"All elements pertaining to the professional practice of medicine."

B. Answers from other hospitals:

"Emergency room would be affected."

"No problem."

"None."

"None."

"None."

II. In answer to the question "What would you do if the supply of foreign medical graduates is cut off?"

A. By state psychiatric hospitals:

"Increase our recruitment efforts."

"Try to get a pay increase."

"Operate with a reduced staff."

"Pray for the good health and longevity of those physicians we have"

"Terminate many of the programs."

"Redistribute workloads to the remaining medical staff to an undesirable quality level."

B. By other hospitals:

"We would find others."

"We would intensify our recruitment effort."

"No problem."

"Fill the positions with U.S. graduates."

"We don't really require FMGs."

"We would use U.S. and Canadian medical school graduates."

III. Other comments by respondents:

"Patient cost will go up."

"Most FMGs have done an excellent job."

"Without our FMGs, even minimal standards of patient care would not have been met."

"Most FMGs do not have the training of U.S. graduates."

"We are already replacing our FMGs with American graduates."

Conclusions and Projections

It is obvious from this study of the impact of the loss of salaried foreign medical graduates to Georgia hospitals that the impact will be slight except on state hospitals. These seven state hospitals in the study employed half of the total number of FMGs in Georgia and some of the comments by the respondents to the questionnaire show clearly that the loss of FMGs will have a serious effect on state hospitals in Georgia, but not on any non-state hospital in Georgia.

A significant number of patients are hospitalized in state hospitals in Georgia. Their medical care depends mostly on salaried physicians in those hospitals. Therefore, the nonavailability of FMGs under PL 94-489 should concern all of us who are citizens of Georgia.

This study would not have been possible without the kind assistance of those at the thirty-one hospitals who filled out the questionnaire.



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Hypertension 1978:
The First Steps of Progress

The Problem

SYSTEMIC ARTERIAL HYPERTENSION affects one in six adult Americans and contributes to the morbidity and mortality of several other major cardiovascular problems, including cerebrovascular accident, myocardial infarction, congestive heart failure and chronic renal failure.

What Has Been Accomplished

Intensive public and professional educational efforts over the past decade have increased the general awareness of the problem of hypertension and of the need for its management.

About 60% of hypertensive individuals are now aware of their diagnosis, with two-thirds receiving treatment and one-half of these having their blood pressure adequately controlled. This represents a favorable change, but, obviously, represents just the first steps of progress.

Equally important, an increasing proportion of the public now understands that hypertension is an asymptomatic disease, with the first presentation often being the life-threatening complications of cerebrovascular accident or acute myocardial infarction; therefore hypertension detection requires measurement of the blood pressure. The 60-75% of patients whose elevated screening blood pressure can be confirmed should be referred for medical management. Patients with more labile blood pressures should be rechecked at least annually. It is also increasingly understood that less than 5% of hypertension can be "cured." Blood pressure control involves a lifetime of medication-taking, with periodic medical surveillance for adequacy of control.

Medical professionals now appreciate that control of blood pressure is no longer satisfactory when diastolic pressures remain in the 95-105 mm Hg range. Systolic hypertension is as equally or more predictive of cardiovascular complications than is diastolic hypertension.

In the past decade, deaths from hypertension and hypertensive cardiovascular disease have decreased by 44%. Thus, with hypertension known to increase the risk of coronary heart disease about threefold and the risk of stroke about sevenfold, it is not surprising that hypertension control has been associated with a decrease in stroke and heart attack deaths.

What Remains to Be Done

The term "essential hypertension" remains an indictment of our lack of knowledge of the cause of this common problem. Identification of the etiology or etiologies is

basic to attempts at our ultimate goal—prevention; thus, hypertension research must remain a national priority. In the interim, intensive efforts must be directed toward developing effective, long-acting, safe and inexpensive antihypertensive medications. Dietary and relaxational techniques are currently considered adjunctive rather than primary therapies for fixed hypertension. Public and professional educational efforts about hypertension must be heightened in an effort to detect, treat and control an increasing percentage of hypertensive Americans.

Activities of the Georgia Heart Association

May has been designated as National High Blood Pressure Month. This May, the Georgia Heart Association will emphasize both public and professional education about hypertension, its detection and management. Some designated areas will also conduct blood pressure screening, using trained community volunteers. Individuals identified as having an elevated blood pressure will be referred for medical management.

Nanette Kass Wenger, M.D.
President
Georgia Heart Association and
Professor of Medicine (Cardiology)
Emory University School of Medicine

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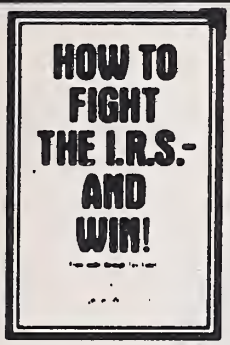
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president's letter



Goals for the Coming Year

WELL, ANNUAL SESSION '78 is history now. Your representatives met at Jekyll Island, cussed and discussed the issues and charted a course of principles and guidelines for us to follow. It is my intention to adhere as closely as possible to the wishes of our House of Delegates.

I have two primary goals for the coming year. First, unity of our profession. We need to join together in spirit and mind and strengthen our association, support GAMPAC and AMPAC, corral our legislators, and give our time and financial support to our local, state and national organizations. Our profession is not perfect and people do not expect us to be. We are honest and respected. We must become active with positive alternatives and be willing to negotiate. We alone have the special expertise necessary to make health decisions. We must stand together, work together and create in America a health system second to none and accepted by everyone at a cost everyone can afford.

My second goal is in the field of nutrition. Georgia ranks 48th in the United States in life expectancy. Education of physicians and patients alike in preventive medicine and nutrition is a powerful and positive approach to solving the health care problems of this country. Out of 120 medical schools in the United States, only six have formal courses in clinical nutrition. Physicians are taught to treat disease and not prevent disease.

The future is unlimited. We have within our power the ability to eradicate most of the common illnesses confronting us today. Let's get organized. Let's set up a task force on nutrition and separate the wheat from the chaff and get on with providing the best health care for the greatest nation on earth, the United States of America.

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I've told this before . . .

(Editor's note: If you think you've heard fish tales before, try this one on for size. It's a whale of a tail! Others wishing to share their stories with our readers are invited to send them to the Journal *for consideration. The address is 938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Bess—A Fish-Catching Cow

MANY YEARS AGO, my brother Eli invited some of his friends and me to go on a duck hunt with him in the pin oak forests of Arkansas. He was sort of a public relations man with the Cotton Council and lived in Memphis.

We had had a good hunt; it was cold outside, but we had gotten warm, had a bountiful meal and sat around an open fire doing the things and discussing the things that hunters are wont to do throughout the world.

After a few "hard to believe" stories had been told, Eli asked "if anyone had ever seen a cow that could catch fish!!!" No one said anything, but there were dubious looks all around, which seemed to hurt his feelings a little, but that didn't keep him from telling his story.:

One Friday afternoon in July, two years ago, said my brother, I was on my way home and dropped by to see a cotton farmer in northern Mississippi. As I was getting ready to leave, I noticed an eight to ten-acre farm pond not far from his house.

"That's a pretty lake you have there, Mr. Clodfelter," I said. "It looks like a good fishing lake!"

Mr. Clodfelter said that there were fish in it and suggested that he bring his fishing tackle the next time and try it. Suddenly, Eli said he remembered that his fly rod was in the trunk of the car.

"I fished," said Eli, "for a couple of hours and caught three small bass."

Mr. Clodfelter was there when I landed the boat and looked at the fish with some disgust.

"Why, Ole Bess can catch more fish than that . . . come on and I'll get her to catch you some, at least a mess to take home with you."

They walked toward three milk cows that were contentedly grazing with their heads down and their tails continuously in motion as they swatted little and big flies from off their sides and backs.

Bess turned out to be a big black milk cow that had a tail that almost reached the ground and it seemed that late in the afternoon after they had had their fill of grass, the cows enjoyed walking out into the pond to belly-deep in water. This protected their vulnerable underbelly from the biting flies. It also wet their tails so that when they swatted a pesky fly, it also sent a spray of water to wash off others.

Just before they entered the water, Mr. Clodfelter took from his pocket an artificial fly that looked exactly like a big horse fly. He petted Old Bess a little, stroked her back, gently grasped her tail, selected one of the longest hairs, ran the hair through the eye of the bug twice and put some kind of slipknot above it; then he encouraged Bess to go into the pond to join the other two cows.

Within minutes, they were surrounded by small fish eagerly awaiting any kind of fly to touch the water as they were stunned or killed from the swishing of the cows' lethal weapon. Soon bigger fish joined them and about that time, there was a commotion of the end of Ole Bess's tail. It was pulling her tail first this way, then that, and it was too heavy for her to bring out of the water.

Bess did what she had learned to do over the years; she went ashore, dragging the fish behind her. Ole Man Clodfelter gently removed the fish, reached in his pocket and gave Bess a handfull of boiled cottonseed, then slapped her lightly on the rear and said "Go back and catch another one."

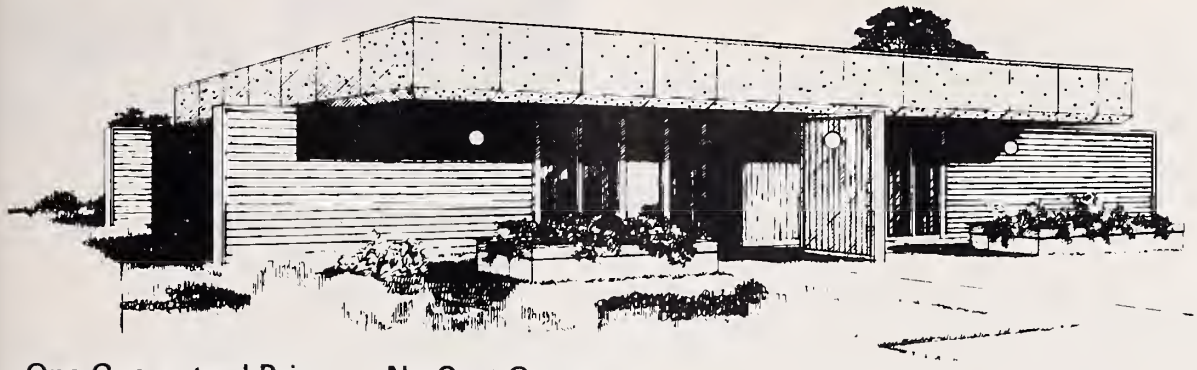
My brother said that Bess caught three nice bass and several big brim before a three- or four-pound bass hit that big fly and when he realized that he was hooked, he headed for deep water with great vigor, so much so that he pulled the hair from Ole Bess's tail—roots and all.

Now Bess did not like this sudden sharp pain in her tail; she let out a pained short moo, looked ruefully at Mr. Clodfelter as though he was responsible, high-stepped it ashore and did a fast walk to the barn.

"Well!" said Mr. Clodfelter, "Her feelings are hurt. She won't give down her milk tonight and it'll be at least ten days before I can coax her to go fishing again."

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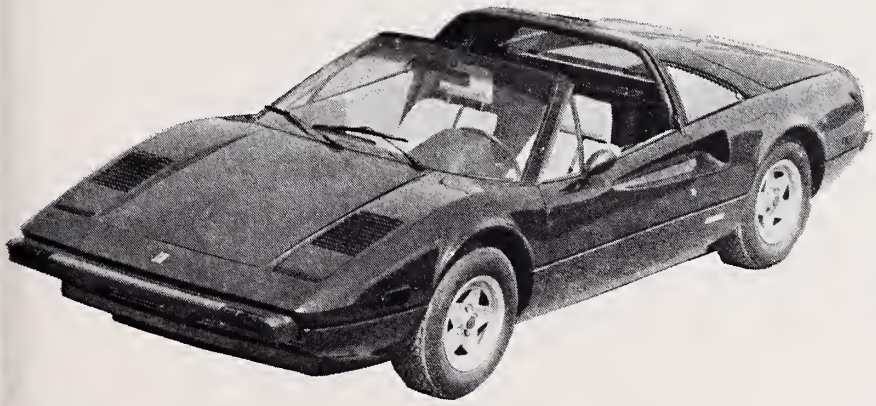
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Mitral Valve Prolapse Syndrome

ROBERT G. OATFIELD, M.D., *Ft. Benning**

PROLAPSE OF THE MITRAL VALVE is a common cardiac disorder which is of considerable interest to the clinician. Although the auscultatory findings were accurately described by Gallavardin in 1913, it was not until the early 1960's that these findings were related to mitral valve dysfunction. Since that time, hundreds of papers have been written about thousands of patients, but we still have disagreement over the clinical significance and etiology of this syndrome.

Patients having mitral valve prolapse are usually diagnosed by their family doctors during routine examinations. Previously, these patients were carried in clinical practice with diagnoses of rheumatic heart disease. We now know that this abnormality can occur secondarily to many diseases, such as Marfan's syndrome, papillary muscle dysfunction, ruptured chordae tendineae, or occurs as a familial trait; however the majority of patients have no clearly definable etiology for the syndrome. The syndrome occurs more commonly in women that in men with a ratio of approximately 3:1, and may occur in as many as 5 to 10% of the general population.

The hallmark of the syndrome is a mid-systolic click or clicks, followed by a late systolic murmur. Associated with these findings are a variable degree of mitral regurgitation on angiography, which is usually clinically unimportant. The high-pitched clicks are best heard at the apex and lower sternal border, and are of variable timing. In contrast, ejection sounds are usually single, heard best at the base of the heart, occur early in systole and vary little in timing. The murmur typically is high-pitched, heard best at the apex, usually begins with the click, is crescendo-decrescendo, and of variable timing. In some patients, the murmur is very loud and has a "whooping" quality. The click may occur with or without the murmur, and

* 106 Miller Loop, Ft. Benning, Ga. 31905.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

vice versa. Usually the typical pattern can be appreciated by various maneuvers. Maneuvers such as standing, Valsalva (strain), and amyl nitrite inhalation tend to decrease left ventricular volume and make the click appear earlier (or become multiple), and the murmur longer, or holosystolic. In contrast, squatting, propranolol, handgrip, and bradycardia, make the click later and the murmur shorter or disappear altogether. It should be stressed however, that in many patients, the auscultatory findings can be evanescent.

The diagnosis of mitral valve prolapse has been facilitated by the use of echocardiography. Although there are flaws in the interpretation, approximately 80% of patients with auscultatory finding of prolapse will have a positive ECHO (i.e. late or holosystolic "hammocking" of the mitral leaflets). Angiography is the most accurate form of diagnosis, but few patients warrant invasive procedures today. Although prolapse patients frequently have a narrow A-P diameter on chest x-ray, there are no specific findings. The electrocardiogram is similarly unrewarding, usually only revealing nonspecific ST-T abnormalities.

Mitral valve prolapse is recognized as a syndrome, because of its frequent association with subjective complaints and unusual occurrence of complications. The most common complaint is of atypical, sharp, intermittent or prolonged left anterior chest pain. However, the pain may be typical of angina pectoris and may even be associated with a positive treadmill stress test. In the appropriate age group, this will cause obvious diagnostic problems. Complaints of dyspnea and fatigue are common, but usually without objective correlates. Palpitations are frequent and occasionally are harbingers of serious complications.

Patients are frequently seen with documented arrhythmias, usually atrial or ventricular ectopic beats. However, a few patients have more serious arrhythmias such as atrial fibrillation or recurrent ventricular tachycardia, and require suppressive medication. Malignant ventricular arrhythmias are thought to be the cause of the rare occurrence of sudden death in these patients. Patients with bothersome palpitations or syncope can be evaluated with 24-hour electrocardiographic monitoring tapes. A small number of patients will have progressive valve dysfunction and will eventually require valve replacement, and a few will require surgery after spontaneous rupture of chordae tendineae. A rare patient will develop bacterial endocarditis, and because of this, it is recommended that the patient be given standard regimen of prophylactic antibiotics prior to dental or surgical procedure. Because 10% of patients with secundum atrial septal defects have associated mitral valve prolapse, patients with mitral valve prolapse should be screened carefully to rule out an atrial septal defect.

Specific therapy directed at problems with mitral valve prolapse is rarely necessary. However, in the occasional patient with incapacitating chest pain, propranolol has been effective in most cases. There are no set dosage schedules, and the usual method is to titrate the drug, beginning with 10 mg QID. Rare patients with chest pain and ventricular arrhythmias have been controlled with several hundred milligrams of propranolol per day.

It should be stressed that the majority of patients are asymptomatic. Except for prophylactic antibiotics, all they require is an accurate diagnosis and understanding reassurances from a trusted physician.

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The Medical Examiners System in Georgia

ROBERT N. BERG, *Atlanta**

THE GEORGIA SYSTEM of medical examiners has been criticized as obsolete and poorly organized, and suggestions for remedial legislation have been debated. At the same time, however, there appears to be considerable confusion about what is in fact provided in the existing Georgia law. A brief review would seem helpful:

In Georgia, the performance of post morten examinations and autopsies by licensed physicians or pathologists is governed by the "Georgia Post Mortem Examination Act," *Ga. Code Ann.* §21-201, *et seq.* (the "Act").[1] Pursuant to the act, the Director of the Georgia Bureau of Investigation (GBI) and the Commissioner of Human Resources are required to authorize one or more licensed physicians or pathologists at convenient locations throughout the state to act as medical examiners in performing post mortem examinations[2] and/or autopsies.[3] There is no formalized selection process whereby the medical skills of a proposed examiner are considered; the Act merely requires that the Director of the GBI "confer with local county officials" before making such appointments.[4]

The medical examiner is required by the coroner to perform post mortem examinations when any person dies in any county in the state "as a result of violence, or suicide, or casualty, or suddenly when in apparent health, or when unattended by a physician, or within 24 hours after admission to a hospital without having regained consciousness, or in any suspicious or unusual manner."[5] In addition, a court having criminal jurisdiction may order a post mortem examination if it is suspected that a person came to his death by foul play.[6]

* Prepared at the request of The Medical Associazion of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

If a post mortem examination is ordered, then the medical examiner has the sole discretion to determine whether or not an autopsy is also required; this grant of discretion is premised, however, upon the medical examiner's giving due consideration to the opinions of the peace officer in charge regarding the requirements of accepted investigation techniques and the applicable rules of evidence.[7] Additionally, the medical examiner may, in appropriate cases, obtain an order from the superior court for disinterment of the body.[8] Thereafter, the medical examiner is required to reduce his findings to writing and file this report with the GBI.[9]

The fee to be paid to the medical examiner is set out in the Act: (1) in cases where dissection of the body is not required, the medical examiner shall receive a fee of $35; and (2) in cases where dissection of the body is required, he shall receive a fee of $110 for a partial post mortem examination and autopsy and a fee of $150 for a complete post mortem examination and autopsy. This fee is paid by the county in which the act resulting in the death was committed; if the county in which the act was committed is unknown, the fee is paid by the county in which the body was found.[10]

Although some of the criticism of the present system relates to the inadequacy of the fees provided for the medical examiners, the more fundamental criticism is that it fails to provide for a well-organized scheme of supervision over the activities of the medical examiners by qualified medical personnel. Rather than creating a supervisory body to coordinate and oversee the performance of duties and the maintenance of records, and to insure minimum and uniform standards of excellence, the Act places supervision over the activities of the medical examiners in the hands of the GBI.

The medical examiners systems in other states highlight the inadequacies of the present Georgia system. For example, in Florida, a "Medical Examiners Commission" was created to promulgate guidelines and to specifically govern and supervise the activities of the individual medical examiners.[11] This Commission, in turn, is authorized to create "medical examiner districts," and submit nominees for the medical examiner of each district to the governor of the State from among the practicing pathologists in each district. Thereafter, these districts medical examiners are authorized to appoint as many physicians (as associate medical examiners) as are necessary to provide service at all times and at all places within the district.

In conclusion, although the existing Georgia medical examiner system may not be as antiquated as it is sometimes depicted, it does appear that there is substantial room for improvement. An analysis of the medical examiners systems enacted in other states, such as Florida, leads to the conclusion that the Georgia system could be significantly improved both in the area of the selection of the individual medical examiners and in the area of the coordination of and supervision over the activities of these examiners.

(Editor's note: For additional discussion on this subject, see *JMAG*, April 1978, pp. 282 and 299.)

Notes

1. Acts 1953, p. 602 *et seq.*, as amended by Acts 1960, p. 1009 *et seq.;* Acts 1961, p. 437 *et seq.;* Acts 1969, p. 761 *et seq.;* and Acts 1974, pp. 563, 654.
2. *Ga. Code Ann.* §21-202(1) defines "post mortem examination" as "an examination after death includ(ing) an examination of the dead body and surroundings by the medical examiner and peace officer in charge, but not includ(ing) dissection of the body for any purpose."
3. *Ga. Code Ann.* §21-202(2) defines "autopsy" as "the dissection of a dead body and the removal and examination of bone, tissue, organs and/or foreign objects for the purpose of determining the cause of death and circumstances surrounding the same."
4. *Ga. Code Ann.* §21-203(2).
5. *Ga. Code Ann.* §21-205(1).
6. *Ga. Code Ann.* §21-205(3).
7. *Ga. Code Ann.* §21-203(3).
8. *Ga. Code Ann.* §21-221.
9. *Ga. Code Ann.* §21-209.
10. *Ga. Code Ann.* §21-203(5).
11. 27 *Fla. Stat.* §406.1 *et seq.*

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SOCIETIES

A recent program at the meeting of the **Crawford W. Long Medical Society** was on "Identifying and Dealing with Child Abuse." The program was presented by Robert ten Bensel, M.D., who was introduced by Mrs. Joan Curtis.

New officers for the **Dekalb County Medical Society** are: H. Duane Blair, M.D., president; Charles McDowell, M.D., president-elect; Wytch Stubbs, vice president; and Ernest Fokes, M.D., secretary-treasurer. Board of Trustees members are: LaMar McGinnis, M.D.; Lawrence Freeman, M.D.; Stanley P. Aldridge, M.D.; John P. Heard, M.D.; William R. Hardcastle, M.D., and Theodore C. Whitson, M.D.

PERSONALS

First District

Savannah psychiatrist **Simon V. Speriosu, M.D.,** has been appointed clinical director of Georgia Regional Hospital at Savannah. The head of the Children and Adolescents Psychiatric Unit of the same hospital since August 1972, Dr. Speriosu had been acting clinical director since August of 1977.

Second District

Marshall C. Dunaway, M.D., of Thomasville, recently addressed the first public program on "Learning to Live with Heart Disease," sponsored by Archbold Memorial Hospital's Ernest F. Wahl Cardiovascular Center and Department of Education and Training and the Thomas County Heart Unit. Dr. Dunaway explained to members of the public that heart patients can often return to productive lives if they follow treatment plans.

Moultrie physician **James H. Stone, M.D.,** has been named a diplomate of the American Academy of Family Practice.

Third District

John G. Bates, M.D., of Cuthbert, has been named a diplomate of the American Board of Family Practice.

Fourth District

Kenneth Alonso, M.D., medical director of Laboratory Procedures South, Decatur, spoke at a symposium "Estrogen and Progesterone Receptors in Breast Cancer" at the M. D. Anderson Hospital, Houston, Texas, in April.

The American Board of Family Practice has named **Stephen B. Edelson, M.D.,** Decatur, a diplomate. Dr. Edelson was also named a fellow by the American Academy of Family Physicians.

Fifth District

Atlanta physician **Nicholaus Davies, M.D.,** spoke on "Continuing Medical Education and the Hospital Library" at the Southeast Hospital Conference for Hospital Librarians in April at the World Congress Center.

The American College of Radiology has named as fellows **Elwin W. Donnelly, M.D.,** and **John R. McLaren, M.D.**

Wadley R. Glenn, M.D., medical director of Crawford W. Long Memorial Hospital, was honored by many people in February. February 10, 1978, was declared Wadley R. Glenn Day in Atlanta, by Mayor Maynard Jackson. In ceremonies at CWL and at the hospital's annual black tie ball, Dr. Glenn received many tokens of appreciation for over 40 years of service on the clinical faculty of Emory University School of Medicine and for 35 years as medical director of the hospital. He was also honored by Blue Cross and Blue Shield of Georgia/Atlanta, the Trust Company of Georgia, and Atlantic Steel Company for distinguished service as a member of their governing boards. Emory University presented him with a resolution citing his "outstanding achievements as an engineer, physician, teacher, administrator, industrialist, manager and philanthropist." Two bound volumes of letters of tribute from associates and friends were also presented to him from Crawford Long.

The prestigious Robert Wood Johnson Health Policy Fellowship has been presented to **Donald O. Nutter, M.D.,** professor of medicine (cardiology), associate professor of physiology, and director of the Medical Scientist Program, Emory University School of Medicine. The fellowship provides a year's study of federal health policies in Washington, D.C. The training is designed to help the fellows assume health leadership roles from the community to the federal level.

William E. Silver, M.D., recently presented a paper "The Surgical Role of the Nose in Aesthetic Facial Surgery" to the Metropolitan Atlanta Surgical Orthognathic Study Club, in a two-day program attended by oral surgeons, orthodontists, plastic surgeons and cosmetologists.

Sixth District

Macon psychiatrist **George Henry, M.D.,** has been elected into membership of the American College of Psychiatry.

Milton I. Johnson, M.D., immediate past president of MAG, and **Charles Lanford, M.D.,** have been recertified by the American Board of Family Practice.

J. Morgan Kellum, M.D., and his wife Edith attended

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Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

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the "South American Adventure" medical seminar in Lima, Peru and Quito, Equador, co-sponsored by MAG, MAA and the DeKalb County Medical Society. Their son, John Kellum, M.D., assistant professor of surgery at Tufts University New England Medical Center, Boston, recently gave a lecture in Waterville, Maine, to a continuation postgraduate course on biliary tract disease.

Macon physician **J. Benham Stewart, M.D.,** helped present a continuing education program in Tampa, Florida, before the American Society of Abdominal Surgeons Study Center.

Herbert D. Tyler, M.D., of the Tyler Clinic in Thomaston, has been appointed as an Action Council Member to the National Federation of Independent Business (NFIB) in San Mateo, California, and Washington, D.C. NFIB is a non-profit, non-partisan organization founded in 1943 and designed to "promote the concept of free enterprise and to give independent business a greater voice in shaping the laws which govern business and government."

Seventh District

Homas H. Curtis, M.D., has been recertified by the American Board of OB/Gyn. He was originally certified in 1962.

Gerald Kumin, M.D., has been appointed to serve on the Department of Medical Assistance's Advisory Committee for the Georgia Prospective Reimbursement Project, designed to determine the feasibility of implementing a prospective reimbursement system for inpatient services in the Atlanta area.

Tenth District

Augusta's St. Joseph Hospital has elected **John C. Markham, III, M.D.,** chief of staff. He will chair the executive board of the medical staff. Other board members elected are **Maynard Nelson, M.D.,** vice chief of staff, and **Robert Hill, M.D.,** secretary.

TWO STAFF MEMBERS JOIN MAG

Two new people have joined the staff at MAG headquarters.

J. Tom Sawyer started work on March 6 as Assistant Executive Director-Administration, replacing J. Sherwood Williams who left MAG to start his own business.

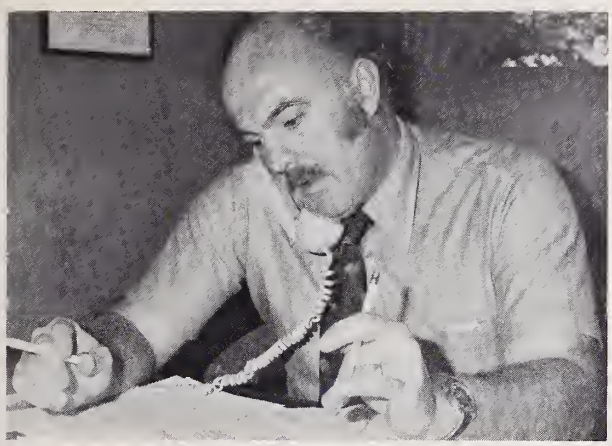
Mr. Sawyer comes to MAG from the Tennessee Medical Association, where he was executive assistant and field representative, serving as liaison between the state and the county medical societies. While at Tennessee, he directed the TMA printing division and staffed several committees.

Mr. Sawyer was headquartered in Atlanta from 1968 to 1976, where he was the regional director for public affairs for the American Medical Association.

A native Tennesseean, he received his B.S. degree from the Middle Tennessee State University in Murfreesboro, Tennessee. He is married and has two children.

In his new position, he will be responsible for MAG Services (print shop) and the coordination of the Annual Session meetings. He will also staff several committees, including Disabled Doctors, Professional Conduct and Medical Ethics, and Access to Health Care.

Joyce Butler, R.N., officially joined the MAG staff on May 1, though she is not a stranger to MAG. She was Director of CHAMPUS from 1966 until the contract was lost earlier this year.





Born and raised in Tennessee, Mrs. Butler received her R.N. degree from Baptist Hospital in Nashville. She held positions there as assistant nursing arts instructor, assistant head nurse on a 33-bed medical unit, and assistant coordinator of Auxiliary personnel. She moved to Atlanta in 1959 and joined CHAMPUS in 1961 as assistant administrator.

She is married, has four children and five grandchildren.

In her new position, Mrs. Butler will staff several committees, including Access to Health Care, Health Planning, Cost Containment and Peer Review. She will also work on matters relating to HMOs, HSAs, Blue Cross/Blue Shield and Medicare/Medicaid.

RESIDENTS LIKE WORKSHOPS

This year, the MAG's Division of Education expanded its activities by sponsoring two workshops for house staff on setting up a medical practice. Both were held in Atlanta, with Conomikes Associates of California conducting the first one in early February and Practice Productivity of Atlanta the second in late March. Overall attendance was 51, indicating a definite need in an area which is

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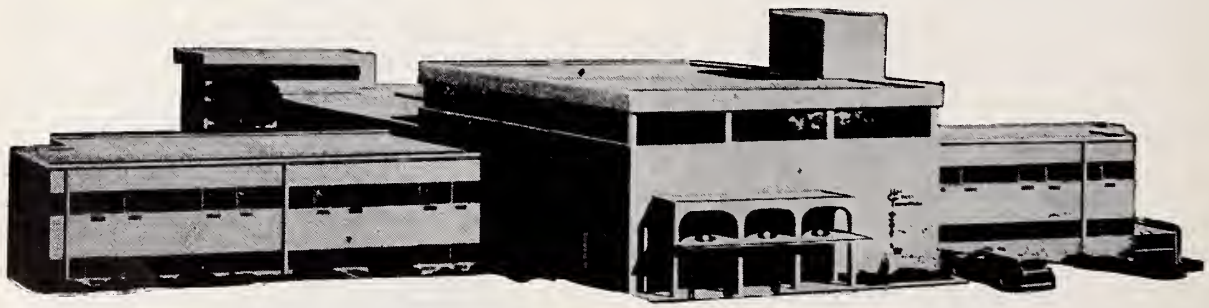
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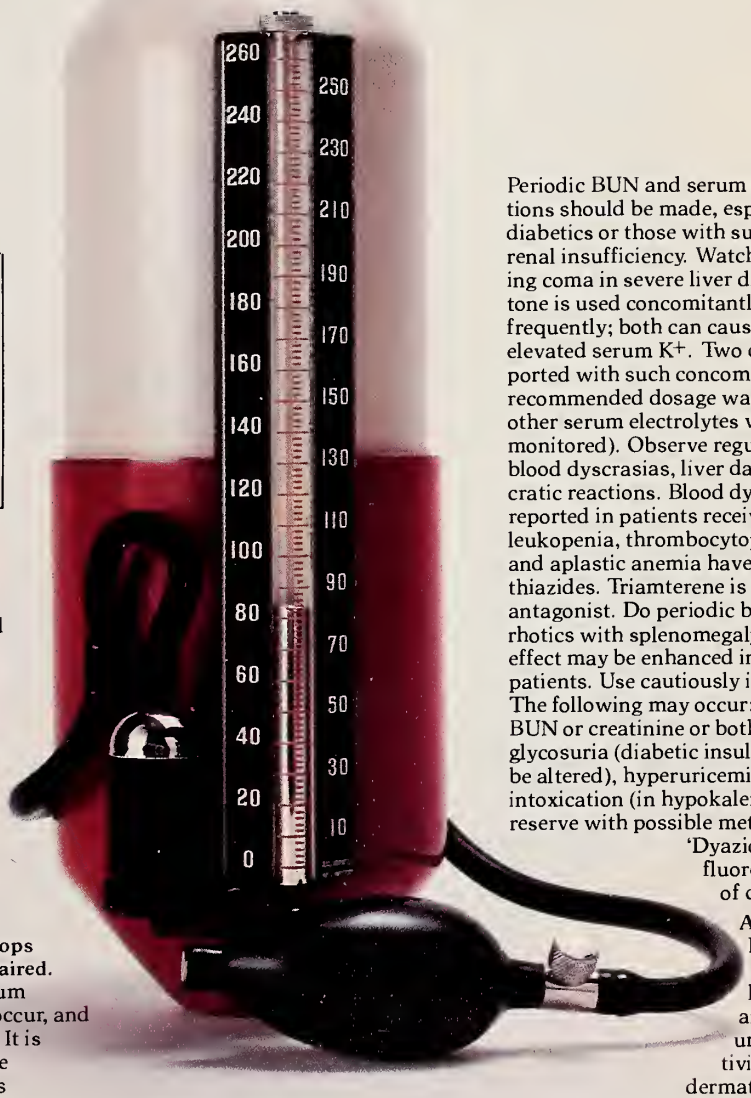
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MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

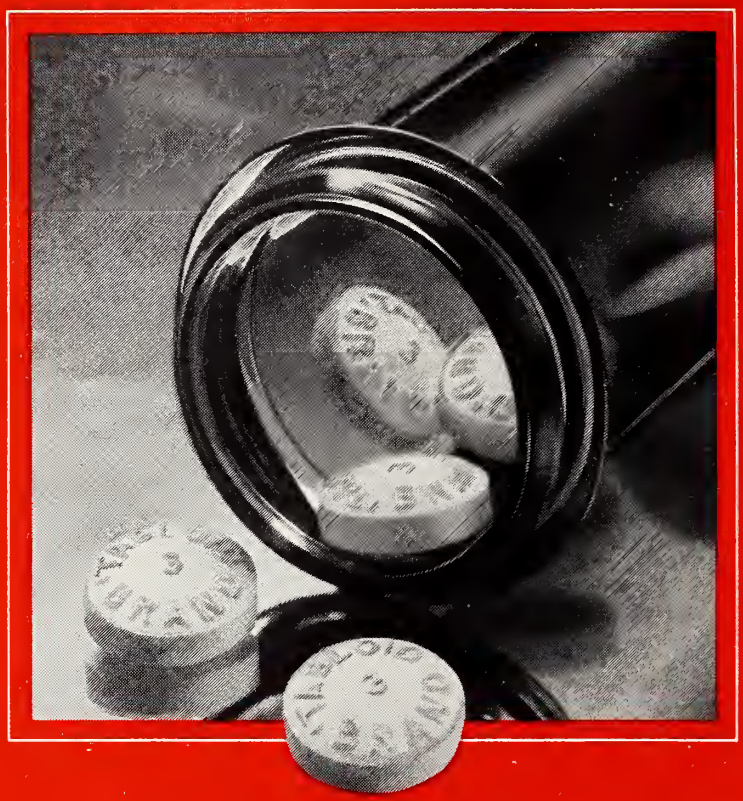
Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

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C-III

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often absent in traditional medical education curricula.

Twenty-nine of the participants were in residency programs in Georgia and the others hailed from six other southeastern states. Family practitioners and internists constituted the majority, and pediatricians, btolaryngologists, and obstetrician/gynecologists were well represented. Also participating were a general surgeon, a psychiatrist, a urologist, an orthopedic surgeon, a physician's assistant, and the executive director of a family practice residency program.

Locales selected by the residents for their practices include: Atlanta, Augusta, Thomaston, Athens, Gainesville and Dahlonega in Georgia; High Point and Brevard County in North Carolina; Opelika, Alabama; Winchester, Tennessee; Ocala, Florida, and California, Wyoming, Idaho, and Hawaii.

The workshops focused on such aspects of office practice as: hiring, managing and firing personnel; setting up financial and medical records systems; appointment scheduling; use of physical office space, and handling insurance forms. The residents gave high marks to the workshops, as illustrated from the following comments on evaluation forms: "An outstanding presentation," "An extremely valuable and excellent course," "Enjoyed it, will recommend to colleagues," "Most I've learned in two days in my life."

Dates for next year's pre-practice workshops have not been set, but plans tentatively include one in Augusta and one in Atlanta. Similar workshops for practicing physicians and their employees are also being contemplated. For information, contact MAG's Division of Education.—**S.L.D.**

DEATHS

William Rhesa Jones

Long-time Columbus physician, William Rhesa Jones, M.D., died April 15 in Houston, Texas, at the age of 86.

Dr. Jones served on the pediatrics staff of the Medical Center, St. Francis Hospital and Cobb Memorial Hospital for over 40 years.

Charles McCord Kilpatrick

Retired Richmond County physician Charles McCord Kilpatrick, M.D., died March 13 following an extended illness.

Survivors include his wife, Martha Stelling Kilpatrick; three sons, Zachery McCord Kilpatrick, M.D., Richard Cree Kilpatrick and Andrew Jones Kilpatrick, II, Augusta; one brother.

Walter Lee Shepeard

Walter Lee Shepeard, M.D., of Augusta died March 16.

Dr. Shepeard was on the faculty of the Medical College of Georgia from 1948 to 1971. He had worked in the Department of Pathology and served as chairman of the Department of Medical Technology. He was awarded an honorary membership in the American Society for Medical Technology in 1972, and the Dr. Walter L. Shepeard Achievement Award was established in his honor.

Survivors include his wife, Enid Hopson Shepeard, Augusta, and one sister.

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About a Personal Financial Plan

The TRA '76 — that's the Tax Reform Act of 1976, became effective January 1, 1977 and is being phased in over the next five years. It affects wills, trusts, investments and other financial transactions. Each of these needs to be reviewed in the light of the TRA '76. Its impact on your personal financial situation may require professional evaluation.

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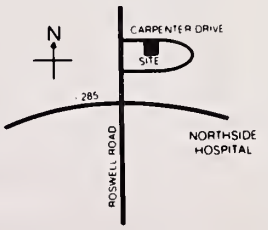
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EACH SUGAR COATED TABLET CONTAINS:

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NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

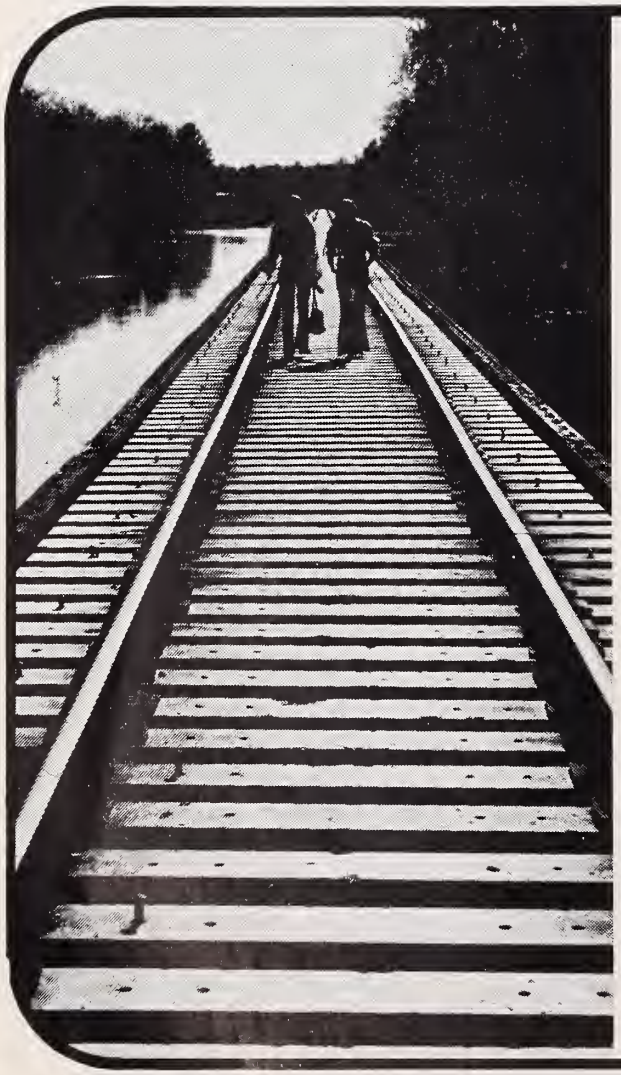
CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

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SUNBELT COMMUNITY EMERGENCY PHYSICIAN—La Grange, only 60 miles southwest of Atlanta. Immediate opening for experienced emergency department staff physician in beautiful southwest Georgia setting. Fantastic recreational area! $45,000 plus benefits. Send curriculum vitae to Warren Ingalls, M.D., Director of Emergency Services, West Georgia Medical Center, 1514 Vernon Road, Box 1169, LaGrange, Georgia 30240, or call toll free 1-800-325-3982, Ext. 220.

FAMILY PHYSICIAN or General Internist wanted to join two-man, well-established family practice, no O.B. Pleasant community of 50,000. Modern 225-bed hospital, excellent benefits. May inquire through William L. McDaniel Jr., M.D., or Robert W. Simmons, M.D., 1203 Memorial Dr., Dalton, Georgia 30720. Telephone (404) 278-0138.

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EMERGENCY PHYSICIAN—Community hospital, 1¼ hours from Atlanta. Pay—$50,000 per year for 2½ days per week, plus free insurance. Call (415) 435-0689 or 435-9751.

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MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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JOURNAL
of the medical association of
georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

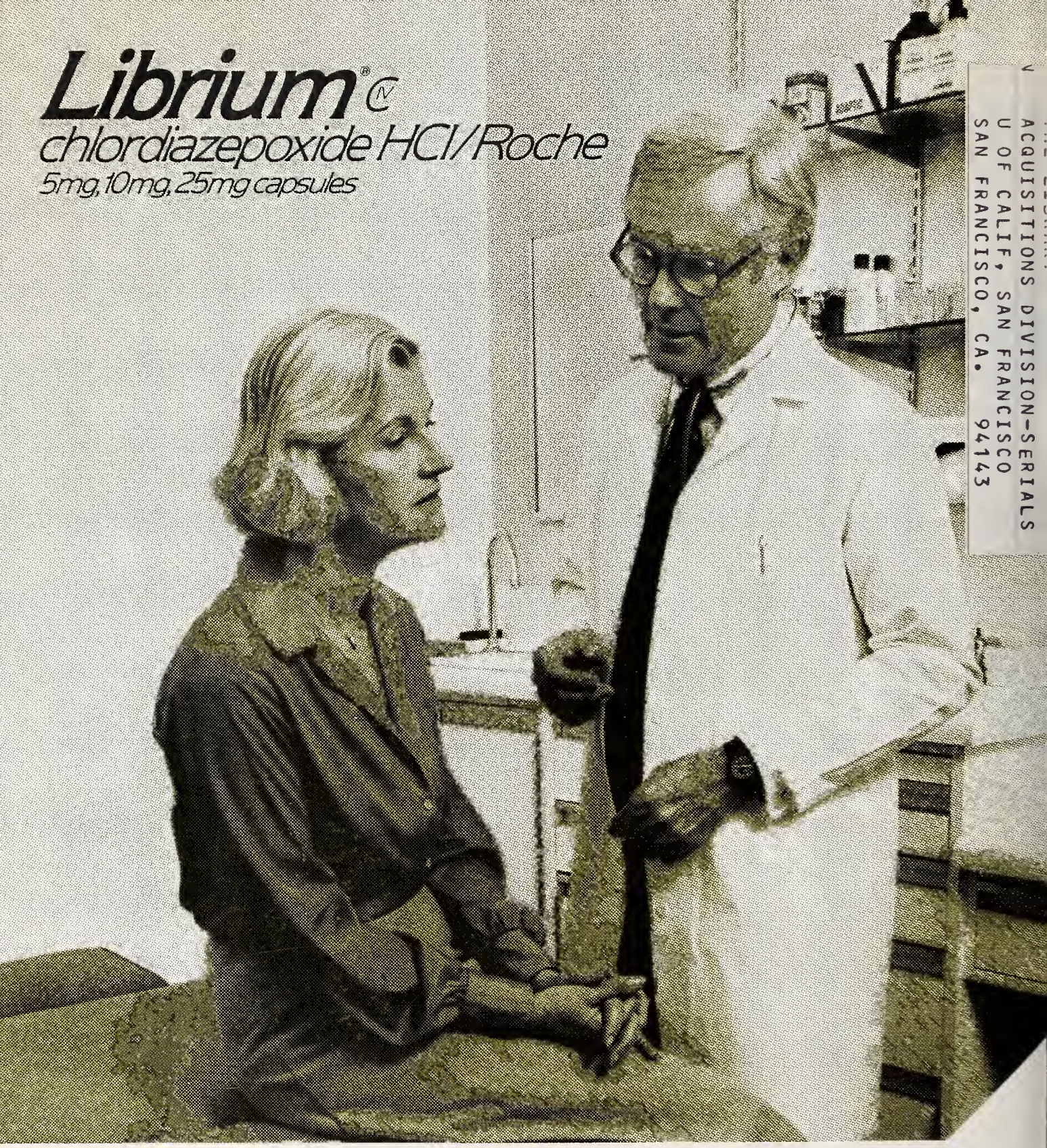
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Breast Cancer
Diagnosis and Management



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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically assess the individual patient

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals [illegible] addiction and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-[illegible]

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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MEDICAL MEETING CALENDAR

JUNE

29-July 1—*Hilton Head, SC;* **GENERAL PEDIATRICS;** Category 1 Credit; Contact: American Academy of Pediatrics, 1801 Hinman Ave., Evanston, IL 60201.

29-July 1—*Myrtle Beach, SC;* **PEDIATRICS BEACH WEEKEND;** Category 1 Credit; Contact: Bowman Gray School of Medicine, 300 South Hawthorne Rd., Winston-Salem, NC 27103.

JULY

3-5—*Wrightsville Beach, NC;* **8TH ANNUAL SPORTS MEDICINE SYMPOSIUM;** Category 1 Credit; Contact: Frank C. Wilson, M.D., North Carolina Memorial Hospital, Chapel Hill, NC 27514.

6-9—*Hilton Head, SC;* **CONTEMPORARY CLINICAL NEUROLOGY;** Category 1 Credit; Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, TN 37212.

7-9—*Orlando, FL;* **ANNUAL CLINICAL CONFERENCE ON PRE-HOSPITAL EMERGENCY CARE;** Contact: Julius M. Garner, M.D., ACEP, Florida Chapter, 600 Courtland St., Ste. 420, Orlando, FL 32804. PH: 305/628-4800.

8—*Knoxville, TN;* **NEW DEVELOPMENTS IN PEDIATRICS AND FAMILY PRACTICE;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

10, 13, 17, 20, 24, 28—*Atlanta;* **INSTITUTE/SEMINAR ON HUMAN VALUES IN HEALTH CARE;** Contact: Jack Boozer, Department of Religion, Emory University, Atlanta 30322. PH: 404/329-7596.

10-14—*Atlantic Beach, NC;* **ANNUAL DUKE MEDICAL POSTGRADUATE COURSE;** Category 1 Credit; Contact: M. Henderson Rourk, M.D., Duke University Medical Center, Durham, NC 27710.

10-14—*Jekyll Island;* **TAX, RETIREMENT, AND ESTATE PLANNING AND FINANCIAL INVESTMENTS;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

12—*Knoxville, TN;* **NEW DEVELOPMENTS IN RADIOLOGY;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

13-14—*Atlanta;* **PHYSICAL IMPAIRMENT AND DISABILITY: ASSESSMENT AND PLACEMENT OF THE PHYSICALLY IMPAIRED;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Emory University School of Medicine, Atlanta 30322.

13-16—*Charleston, SC;* **PSYCHOTHERAPEUTIC TREATMENT OF SEXUAL DYSFUNCTION;** Category 1 Credit; Contact: Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29412.

18-21—*Atlanta;* **MEDICAL OFFICE MANAGEMENT INSTITUTE;** Contact: Conomikes Associates, Inc., 4270 Promenade Way, Marina del Rey, CA 90291. PH: 800/421-6512.

23-28—*Asheville, NC;* **ANNUAL MEETING, SOUTHERN OBSTETRIC-GYNECOLOGICAL SEMINAR, INC.,** Contact: W. Otis Duck, M.D., Drawer F, Mars Hill, NC 28754.

25-27—*Washington, DC;* **NATIONAL DISEASE PREVENTION CONFERENCE;** Contact: AMA, 535 North Dearborn St., Chicago, IL 60610.

30-August 2—*Orlando, FL;* **COMPUTERIZED TOMOGRAPHY AND PATIENT MANAGEMENT;** Category 1 Credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

31-August 2—*Jekyll Island;* **PEDIATRICS—COMMON OFFICE PROBLEMS;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

31-August 4—*Myrtle Beach, SC;* **SIXTH ANNUAL BEACH SYMPOSIUM;** Category 1 Credit; Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, 300 South Hawthorne Rd., Winston-Salem, NC 27103.

31-August 5—*Atlantic Beach, NC;* **CURRENT CONCEPTS IN DIAGNOSTIC RADIOLOGY INCLUDING ULTRASOUND, CT SCANNING AND NUCLEAR MEDICINE;** Category 1 Credit; Contact: Robert McLelland, M.D., Radiology—Box 3808, Duke University Medical Center, Durham, NC 27710.

AUGUST

2-6—*Orlando, FL;* **DIAGNOSTIC IMAGING OF THE HEART;** Category 1 Credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

6-13—*Cashiers, NC;* **SECOND ANNUAL SMOKY MOUNTAIN SEMINAR IN GYNECOLOGY AND OBSTETRICS;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30322.

8—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE AND UROLOGY;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

10-11—*Atlanta;* **UPPER EXTREMITY ADAPTIVE EQUIPMENT;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Emory University School of Medicine, Atlanta 30322.

13-18—*Lexington, KY;* **NINTH FAMILY MEDICINE REVIEW, SESSION II;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506.

14—*Atlanta;* **FAMILY MEDICINE REVIEW—HOME STUDY COURSE;** Category 1 Credit; Contact: Registrar—FMRHSC, GAFP Educational Foundation, Suite 205, 11 Corporate Square, Atlanta 30329.

15-19—*Atlanta;* **MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM COURSE;** Category 1 Credit; Contact: Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

18-20—*Atlanta;* **CARDIAC SYMPTOMS AND ARRHYTHMIAS—THEIR DIAGNOSIS AND TREATMENT;** Category 1 Credit; Contact: International Medical Education Corporation; 64 Inverness Dr. East, Englewood, CO 80110.

22-26—*Birmingham, AL;* **MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM COURSE;** Category 1 Credit; Contact: Registrar, American College of Physicians, 4200 Pine St., Philadelphia. PA 19104.

November 11-14—*Atlanta;* **MAG-SMA SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Roy Evans, Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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Mammography: Benefit or Risk?

JERRY B. BUCHANAN, M.D. and BARBARA F. WEISBERG, R.T., *Louisville, Kentucky**

THERE IS CONCERN that the annual use of ionizing radiation, to detect unsuspected breast cancer in women under 50 years of age, may in fact induce a small number of cancers. This concern was voiced by Bailar[2] in January 1976 and further analyzed and supported by Upton.[9]

Risk

The hypothetical risk involved in the screening for breast cancer seems infinitesimal and at this time remains only a probability. The fact that ionizing radiation at given levels is carcinogenic cannot be argued. What is not known and represents the focus for debate is whether diagnostic radiation at low levels required for today's mammogram can induce breast cancer. Indeed, history records no known case of a breast cancer induced at the current low levels of diagnostic radiation. The information that does exist is based on studies which involve higher levels of radiation, in younger women, at closer intervals (see table).

Based on the evaluation of data from the three separate population groups, the BEIR[1] report in 1972 and the NCI Working Group on Radiation Carcinogenesis[9] in 1977 estimated similar risks in association with radiation exposure to the human breast. The three study groups included young women who received multiple chest fluoroscopies during treatment for pulmonary tuberculosis,[4,7] a small number of young women receiving radiation for treatment of post-partum mastitis[5] and those Japanese women who survived the atomic bomb.[10]

Study	Number of Subjects	*Age (Mean)	Dose (R)	Dose Frequency
Japan A-bomb	11,968	34	10-600	Single
Nova Scotia fluoroscopies	243	26	50-700	Weekly or biweekly
Rochester mastitis	606	27	75-100	Close interval

The best risk estimate, derived from analysis of these data, was only possible by assuming that no threshold exists in regard to radiation effects and that tissue dose response could be linearly extrapolated. Though stated clearly that it is an assumption, a figure of approximately six excess breast cancers per million women screened per rad per year was accepted as prudent. The effect would become apparent following a ten-year latent period.

Benefit

The predicted benefit of screening for breast cancer seems substantial, although this has not been clearly demonstrated for all age groups. The only controlled study to show a benefit related to screen-

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ing for early breast cancer was the well conceived and certainly over-analyzed HIP study of New York.[7] In this program, now in its eighth year of follow up, a significant benefit was demonstrated in those women age 50 years and older. Yet another way to interpret the final results is to state that a significant benefit was demonstrated in only those patients where mammography made a substantial contribution. It is expected that the accuracy of mammography in the 1960's would be reflected in the older population with the less dense, fatty and atrophic breasts.

The absorbed dose to the breast midpoint is so low that mammography decision-making need no longer include concern over radiation exposure.

Moskowitz et al[6] have chosen to look at the data in yet another way. The examination of the case fatality rates for only those women who received the screening examinations (eliminating those 12,000 women not responding to the initial call from the 32,000 selected) a substantial benefit is reflected in all age groups.

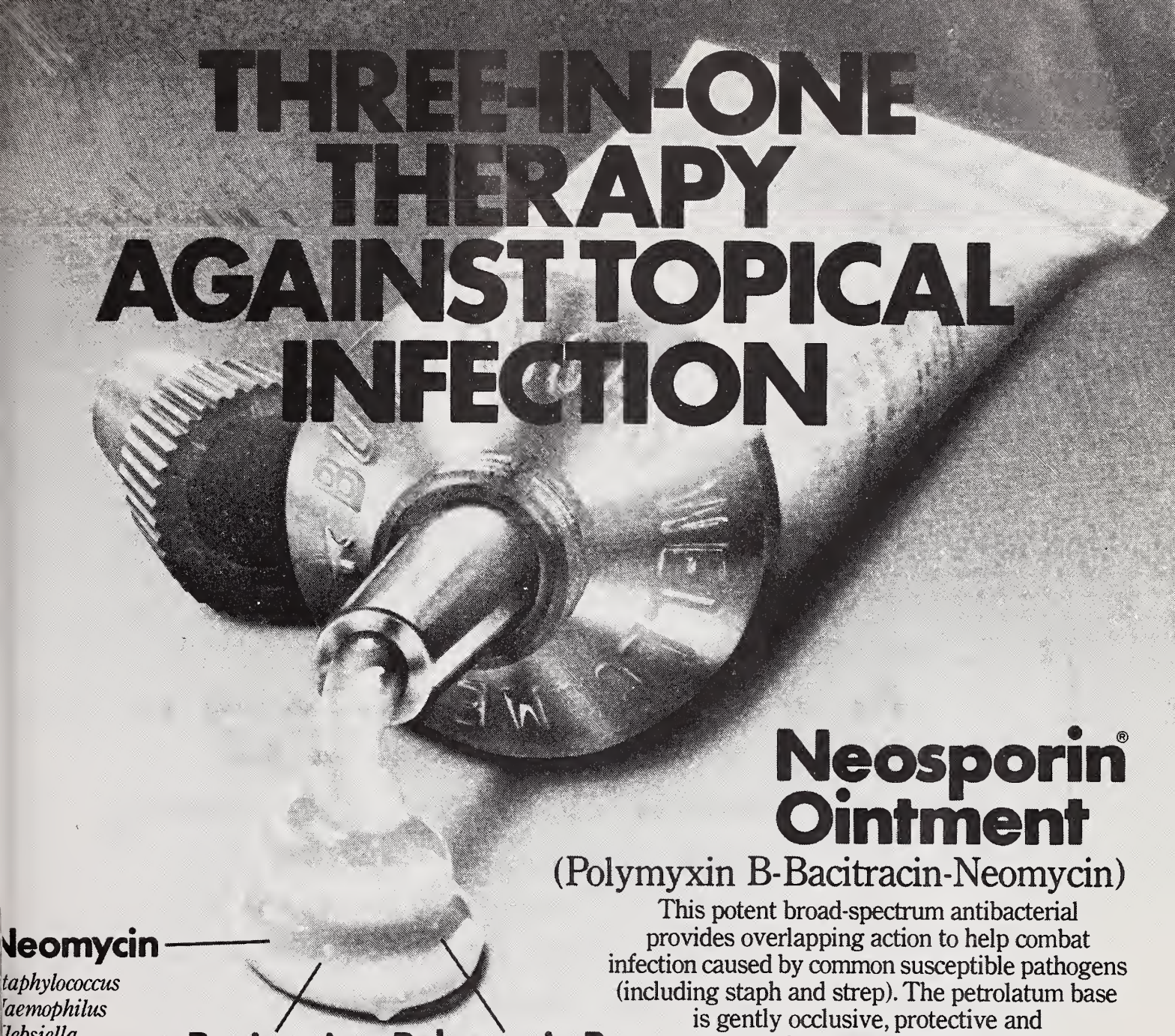
One other data source now available for analysis comes from the preliminary results of the twenty-seven Breast Cancer Detection Demonstration Projects (BCDDPs) jointly funded by the ACS and NCI in 1973 and 1974. With many of these screening centers completing their fourth and fifth annual screens, the results seem promising from a benefit standpoint. The national screening experience reveals over 70% of the screenees with occult breast cancer, whose surgical procedure included nodes that could be histologically examined, free of axillary nodal metastases. Some of the screenees, because of early detection, elected to have a limited surgical procedure and are thus excluded from the negative node category. Thus the actual figure is in all probability well in excess of 70% with negative axillary nodes. Node status historically has been the single most important parameter in determining ultimate survival. Mammography was the single most sensitive indicator of the occult lesions—alone leading to the diagnosis in 45% of the screenees. Of the minimal breast carcinomas thus far confirmed by pathology review, mammography alone detected 244 (65%) of the 374 minimal cancers confirmed. Historically, the detection of breast carcinoma while in its minimal state, with adequate treatment, yields a 20-year survival of over 93%.[3]

It seems unfair, unjust and irresponsible to discourage sound, conscientious health habits on the basis of assumed risks based on today's technology. The technology of mammographic imaging is changing so rapidly that radiation doses in breast cancer screening have decreased over ten-fold in the past two years, with prospects for another ten-fold reduction in the next two years. Using the radiation doses that are achievable today and linear extrapolation accepted by the most severe mammography critics, the estimated risk now becomes a hypothetical figure of one induced breast cancer per *10 million women screened.* Indeed, the absorbed dose to the breast midpoint is so low that decision making in regard to mammography need no longer include concern over radiation exposure. The risk, if it exists, becomes immeasurably small while the benefit may well be life itself.

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Breast Parenchymal Patterns As an Indicator of Risk For Developing Breast Cancer

MARJORIE B. McSWEENEY, M.D., *Atlanta**

MANY HAVE ATTEMPTED to identify a population of women who are at a high risk for developing breast cancer. Wolfe has proposed a correlation between the breast parenchymal pattern as seen on mammography and the risk of developing breast cancer.[2, 3] He devised a classification of four types of breast parenchyma. In a retrospective study, xerograms of 5,284 women with an initial no-cancer examination were classified according to his system. A follow-up averaging two and one-half years was obtained. Those who developed breast cancer within six months of initial mammography were excluded from the study, as their maliganancies were presumed to have been present at the time of the initial examination.

Wolfe found significantly different incidences of developing cancer in each of his four classifications. N1 represents the lowest risk category. The breast is composed primarily of fat and there are no prominent ducts. P1 denotes a low risk group. The P1 breast contains mostly fat with prominent ducts involving as much as 25% of the breast volume. P2 signifies a high risk category in which a prominent duct pattern involves greater than 25% of the breast. The group at highest risk is DY, in whom severe dysplasia produces areas of placque-like density in the breast. This density may be sufficient to obscure an underlying prominent duct pattern. In Wolfe's series, 76% of the cancers were found in the P2 and DY category. This group comprised 27.4% of the population.

Using Wolfe's protocol, 5,918 women over the age of 30 having mammography at Emory were classified.

Using Wolfe's protocol, 5,918 women over the age of 30 having mammography at Emory were classified as to parenchymal pattern. On the initial examination, 327 patients were found to have carcinoma and were excluded from the study. It is interesting that one-third of this population was classified as N1 or P1, and 60% of the cancers were present in this group. P2 and DY included two-thirds of these patients and 40% of the cancers. Also eliminated from the study were the four patients who developed cancer within six months of the initial mammogram. Of these four, one cancer occurred in P1, P2 accounted for one, and two malignancies were in the DY group.

A three-year follow-up of the remaining patients yielded 36 interval cancers. The distribution was: N1—1, P1—2, P2—7, DY—26. This correlates well with the distribution of interval cancers in Wolfe's series with most of the interval cancers occurring in the P2 and DY groups. However, the

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patients were followed for 88 months, and an additional 14 malignancies were discovered: N1—2, P1—3, P2—6, and DY—3. Combining N1 and P1 gives an incidence of 0.21%. The incidence in classes P2 and DY is 0.23%. This distribution is much like the prevalence of malignancy found on the initial mammograms.

If the period of follow-up is limited to two and one-half to three years, the incidence of developing malignancy is similar to that of Wolfe's series. This would indicate that the risk of developing breast cancer increases with increasing breast density. But, after three years, the incidence of interval cancer reverts to the distribution of cancer as found on the initial mammograms. These results do not indicate a greater risk of developing cancer with increasingly dense breast parenchyma. Rather, it is suggested that malignancies are not detected either clinically or radiographically at as early a stage within dense breasts as within fatty breasts. A no-cancer mammogram in an N1 or P1 breast has a higher level of confidence than in a P2 or DY breast. Therefore, by selecting patients with an initial no-cancer mammogram, malignancies in the N1 and P1 population will be more effectively screened out. Those cancers that escape detection initially in the P2 and DY classes will likely become evident within the three year follow-up period. If this is true, then it may be feasible to screen the N1 and P1 population every two to three years. Since the level of confidence in a no-cancer mammogram in P2 or DY is not so great, more frequent screening may be indicated.

In summary, one cannot correlate parenchymal breast pattern with increased risk of malignancy if one extends the period of observation beyond three years. Sixty percent of our malignancies occurred in the N1 and P1 group, which comprised 33% of the total breasts studied.

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Detection of Breast Cancer: Contribution of High Risk Factors

ROBERT L. EGAN, M.D., *Atlanta**

DURING THE PAST TWO DECADES, there has been a drastic change in the old concept of breast cancer as a solitary mass of questionable operability, accompanied with numerous axillary lymph nodes and probable distant metastasis. The application of clinical mammography in 1956[1] in detection of breast cancer prior to signs and symptoms challenged the macabre prognosis of this disease unabated for many decades. The detection of non-palpable cancers following investigation of minimal radiographic abnormalities of the breast demonstrated minimally invasive and noninvasive but irrefutably curable breast cancers.[2] The undreamed-of recognizable preclinical stage of breast cancer has rapidly changed attitudes and reactions in physicians and patients. These changes have paralleled the application of mammography.

A national reproducibility study established mammography as a screening tool.[3] Screening programs of selected asymptomatic programs followed.[4-8] There are current screening projects begun in 1973 by the American Cancer Society and National Cancer Institute in 27 communities reaching only 0.5 per cent of the women in the United States over 35 years of age.

Today, highly productive mammography is available to only a small segment of the female population. But if a predictive procedure could be developed to identify those women most susceptible to breast cancer, they could be concentrated into a small segment of the population for repeated study by mammography. Those women are not now identified except as older women and women with a previous mastectomy for cancer. Since 94 per cent of new born girls will never get breast cancer,[9] a more selective identification of the 6 per cent at risk would surely answer the obligatory challenge to make this medical service available to all eligible women.

New approaches to detection of early breast cancer are needed. Possible epidemiological factors other than age and sex that have been investigated individually, or in limited combinations, have failed to define any patient groups suited for serial mammography. Certain mammographic factors as nonspecific calcifications, fibroglandular patterns and ductal hyperplasia have proved of limited value[10] but, we find, are of greater value in combination with many other indicators. The ultimate role of mammography then would be its application in systematic identification of women in an early phase of developing, or who might be expected to develop, breast cancer. In our unique approach, potential epidemiological indicators of breast cancer with clinical findings and mammography are all used in combinations.

Materials

At the Emory University Clinic from 1963 through 1977, there were 16,687 patient examinations that included history, physical examination and mammography on 7,252 women referred from the oncologic breast service. As there was a breast absent 2,470 times during these studies, there were 30,804 total breast examinations. Of 3,733 breast biopsies, 3,020 were benign and 713 malignant lesions. Over 80 per cent of the cancers were Stage 0 or Stage I histologically. The patients were in high socioeconomic levels and provided good follow-up.

The historical data form included information on: race and religion; socio-economic status; age and

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TABLE 1

Age of Patients and Stage of Cancers in Asymptomatic Patients of the Atlanta Breast Cancer Demonstration and Detection Programs Compared with Symptomatic Patients Referred to Emory University

	Number	Patients Under Age 50 Years	Less Than 1 cm.	Positive Axillary Nodes	Positive Mammograms	*Average Size
BCDDP	132	37%	32%	31%	83%	1.2 cm
Emory University	713	36%	36%	18%	91%	0.9 cm

* In-situ cancers were considered 0 size.

sex; span of normal or abnormal hormonal activity (pregnancies, deliveries, nursing, menarche and menopause, either natural or induced); genetic factors relating to family history, previous breast disease and trauma to the breasts; use of hormones, and nature of complaint. The physical forms included findings in the breast and regional lymph nodes, a tentative diagnosis, stage of carcinoma and an indication for treatment. The radiographic forms included characteristics of the breast, a mass or calcifications if present, abnormalities in the breast, secondary changes of carcinoma, a tentative diagnosis and indication for treatment.

The pathology code consisted of no biopsy, cyst aspirated, benign and not fibroadenoma, carcinoma, carcinoma clinically, fibroadenoma and breast absent.

Prospective data on 114 items, many with up to ten subsets, were collected during each patient examination. Independently, the referring physicians completed the physical, the technologist the historical, and the radiologists the radiographic data forms. These data were entered into computer files, subjected to periodic intensive editing, and the risk factors were examined individually by univariate and together by multivariate analysis for differences in their weights. The nature and magnitude of the risk factors were assessed in concert for any difference that would affect the overall risk for cancer. Categories of risk factors were redefined using contingency tables to reduce the total of the indicators to 64 by eliminating factors associated with advanced cancer or those that were non-contributory. Cross classification analysis was omitted, as it would have required fitting a polynomial with over 2^{64} parameters. Instead, linear, quadratic and hierarchic discriminant analyses were applied.[11]

A newly developed statistical technique of discriminant regional analysis was developed[12] and applied to this fresh approach of assessment of myriad interactions of numerous potential risk factors. These data derived from clinical and radiographic findings in patients with varying stages of breast cancer then indicated their relative risk of having or developing a breast cancer. Calibration of a predictive scheme on 540 cancer and 641 non-cancer patients with validation of a new sample of similar patients was carried out.

Based on the maximum hypothetical risk from mammography, at Emory University approximately 50 studies would be required to raise the natural risk of breast cancer from 0.07 to 0.08 and 350 examinations to double that risk (at 20 minutes per examination, the woman would be x-rayed for 5 days and 5 nights).

Results

The asymptomatic screenee patients of the Atlanta Breast Cancer Detection Demonstration Project were similar to the highly symptomatic referred patients to Emory University in age at diagnosis, size of cancer and stage of cancer except for increased axillary lymph node metastasis in the BCDDP patients (Table 1). Over 1/5 of the cancer patients in both these groups were under 50 years of age. Over 1/3 of the cancers occurred in Emory University asymptomatic patients or in patients without symptoms related to their cancers.

Based on the more frequent signs and symptoms leading to referral for mammography (Table 2) the rate of malignant biopsies ranged only from 24 percent (pain, complaint of mass or complaint without mass) to 33 percent (clinical mass), a variance of only 9 percent. The biopsy rate for clinical mass was 14 times greater than for no complaint, yet increased the incidence of cancer by only three-fold.

This non-specificity of symptomatic versus asymptomatic cancer patients was also found in risk

TABLE 2

Primary Complaints, Biopsy Rates and Malignant Rates of Biopsies, Emory University Symptomatic Patients, by Patient Examinations

Primary Complaint	Number of Examinations	Percent Biopsied	Percent Biopsies Cancer
None	7,262	6	11
Pain	814	8	24
Discharge	280	36	9
Enlargement	120	16	40
Mass	4,230	42	24
Complaint, no mass	2,234	16	24
Clinical mass	3,744	54	33

TABLE 3

Examples of Indicators of Breast Cancer, Occurrence, Biopsy Rates and Results, Emory University Referred Patients, by Breast Examinations (PE is physical examination and Rad is mammography.)

Indicator	Number Of Exams	Number Of Biopsies	Number Cancers Biopsied	Ratio of Cancers to Total Exams	Ratio of Cancers to Total Biopsies
Total breasts	30,904	3,733	713	1:43	1:5
Prior biopsy	7,891	1,283	96	1:82	1:14
Sister with cancer	1,836	180	62	1:30	1:3
Rad—fatty breast	9,392	895	340	1:28	1:2.6
Rad—non-fatty	21,512	2,838	373	1:58	1:7.6
PE—mass	5,180	2,393	581	1:9	1:4.1
Mother with cancer	2,086	206	50	1:41	1:4
Mother, sister cancer	154	22	12	1:13	1:2
Four present*	79	61	64	1:1.23	1:1.02

* Clinical and x-ray mass, clinical and x-ray skin changes.

TABLE 4

Use of Discriminant Analysis and Repartitioning of Indicators by Order Variables to Increase the Sensitivity and Specificity of Certain Indicators Without Effect on Others, 540 Cancers and 641 Non-Cancers, Emory University Referred Patients

Indicator	Raw Frequencies Times Not Occurring	Raw Frequencies Times Occurring	Raw Frequencies Rate of Cancer to Non-Cancer	Repartitioned by Order Variables Times Occurring	Repartitioned by Order Variables Rate of Cancer to Non-Cancer
Increased density by x-ray	460 ca	80	15:1	347	69:1
	635 non-ca	6		5	
Post-menopausal natural	265 ca	275	25:1	215	107:1
	528 non-ca	113		2	
Axillary nodes, by physical	428 ca	112	28:1	112	28:1
	637 non-ca	4		4	

factors usually considered high (Table 3), unless the factors indicated advanced cancer or occurred in less than 0.5 percent of the studied population.

Discriminant analysis and repartitioning by order variables (Table 4) show a marked increased value even in an indefinite finding as vague X-ray density. From a 15:1 raw frequency with cancer to non-cancer, upon repartitioning it became 69:1. A natural menopause similarly increased from 25:1 to 107:1. Yet with advanced signs of cancer there is no, or very little, increase as axillary lymph nodes on physical examination. These patients' profile progressing through pre-clinical cancer have already been established before this stage of disease, and such findings add nothing to the analysis.

In 540 cancers, a mass was present in 408. In 132, the cancer was removed before a mass had formed, in-situ or very minimal invasion. Yet the analytic scheme predicted a mass 524 times, adding considerable credence to the prediction of breast cancer developing.

By selection of patients for biopsy through the statistical analytic scheme, only one-half as many non-cancers patients would require biopsy to demonstrate as many cancers as by clinical examination. If equal numbers of biopsies are done, 92 percent of the cancers would theoretically be detected by this scheme, while only 71 percent would be detected clinically (Table 5).

Discussion

The smallest of the pre-mammography cancers are now considered advanced. Signs and symptoms of these early cancers are non-specific. Selection of patients for future work-up, mammography and

TABLE 5

Relative Effectiveness of Selection of Patients for Biopsy for Breast Cancer by Clinical Evaluation and by Discriminant Analysis in 16,176 Initial Breast Examinations Containing 624 Proved Cancers and 2,028 Benign Lesions at That Examination With a Projected Total of 734 Cancers

	Percent Non-Cancers Biopsied	Predicted Cancers at Risk		Cancer/ Benign Ratio
Clinically	12.5%	552	71%	1:4
Discriminant analysis	11.9%	674	92%	1:2.8
	10.2%	603	82%	1:2.7
	5.6%	513	70%	1:1.8

biopsy is highly subjective. There is no known single, or limited number of, epidemiological factors that can select a woman at significant risk of having or developing breast cancer. Any relatively strong indicators of any nature are associated with advanced disease or can be applied to a limited small segment of the population. The premise then was made that any progress toward establishing a level of risk involves strong statistical procedures involving simultaneous use of many factors, far beyond the scope of cross-classification type analysis.

This approach has indicated clearly that countless combinations of risk factors provide general patterns or clusters without the need to fill completely endless cells for worthwhile clinical predictions. Of 1,181 patients in the calibration, 1,170 had different profiles.

The establishment of precancerous profiles seems at hand. In 540 cancers, a mass was present in only 408, yet was predicted in 524. It seems improbable the scheme erred this widely, as it did predict the 408 cancers having a mass to have one and an additional 116, of the 132 without mass, to have one. The number of basic profiles indicating a mass in the data base of the calibration sample probably was limited and not all-inclusive. Another possibility, assuming any cancer to be life-threatening must proceed through the mass stage, is that some of these histopathologically similar cancers are non-lethal.

The results of hierarchic discriminant analysis of breast cancer demonstrate the feasibility of using simultaneously a large number of risk factors in a systematic way to pinpoint patients with mammary cancer. It is fully realized that the ultimate in selection of proper risk factors for breast cancer has not been attained. However, valuable progress has been achieved in demonstrating that reliable data on risk factors can be highly selective when used in properly applied analytic statistical procedures to produce specific and objective categorization of patient risk. There was little alternative to this original course of groping for useful risk indicators. Yet the approach allows for additions and deletions to data desired and provides for continuous building of myriad risk profiles, their constant elaboration and improved selectivity.

If a predictive procedure could be developed to identify those women most susceptible to breast cancer, they could be concentrated into a small segment of the population for repeated study by mammography.

Conclusion

Large numbers of risk factors in combinations based on epidemiological, clinical and radiographic data can be used to identify effectively patients with a high and low risk of breast cancer. The scheme has been proved possible through meticulous gathering of data and application and development of sophisticated systems of analysis. Objective combination and analysis of many known indicators of breast cancer can produce a substantial reduction in the biopsy rate for breast cancer, while maintaining, or increasing, the number of cancers found on initial examination.

Any progress toward establishing a level of risk involves strong statistical procedures involving simultaneous use of many factors, far beyond the scope of cross-classification type analysis.

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Breast Cancer: New Directions

MELVIN R. MOORE, M.D., *Atlanta**

In recent years, the perception of clinically apparent breast cancer as a systemic disease has gained widespread acceptance. While early diagnosis and appropriate initial management are of the utmost importance, mortality due to metastases continues to thwart efforts to cure the 90,000 women who are diagnosed annually as having breast cancer. Five years from diagnosis, approximately 20% of patients with Stage I, 60% with Stage II, and virtually 100% with Stages III and IV carcinoma of the breast will have relapsed. Thus the majority of patients with breast cancer will die of their disease. Techniques to improve palliative care and prevent death due to distant metastatic spread are being actively pursued. Two such techniques, the use of tissue estrogen receptor assays to guide decisions regarding palliative care, and the use of systemic chemotherapy as part of the initial management of seemingly localized breast cancer, require the active participation of the primary physician who is diagnosing, treating or advising patients with newly diagnosed breast cancer.

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METASTATIC BREAST CANCER—MEDIAN RESPONSE DURATIONS

	ER* Positive	ER Negative
Ooph. or DES†	10 mos.	—
MHA‡	12 mos.	—
TAM§	10 mos.	—
Chemotherapy	10 mos.	10 mos.
Total	42 mos.	10 mos.

*ER = Estrogen receptor.
†Ooph. = Oophorectomy for premenopausal patients.
DES = Diethylstilbesterol for postmenopausal patients.
‡MHA = Major hormonal ablation (hypophysectomy or adrenalectomy).
§TAM = Tamoxifen.

Estrogen Receptors

Estrogen receptor (ER) protein is found in the cytoplasm of over 50% of patients with breast cancer.[1] It is a heat labile protein that can only be assayed in fresh malignant tissue or tissue frozen at −70°C at the time of surgery. Initial biopsy or surgery often provides the only opportunity for obtaining ER values during a patient's course. Those patients whose tumors are negative for ER have less than 10% likelihood of responding to hormonal

treatment for metastatic disease; those patients whose tumors are ER-positive have approximately a 50% chance of responding to any form of hormonal treatment for metastatic disease.

As discussed above, the majority of patients with breast cancer will have clinically apparent metastases. The importance of obtaining tissue for ER at the time of initial diagnosis or at the time metastases are documented (when malignant tissue is easily accessible for biopsy, e.g., nodes, skin, subcutaneous) can be illustrated by the median response durations for various hormonal manipulations and chemotherapy shown in the table. An ER-negative patient would not be expected to respond to any of the hormonal manipulations listed and could therefore be spared unnecessary medical and surgical interventions. Such patients would have about a 50% chance of responding to combination chemotherapy, but with a median response duration of only 8 to 14 months. An ER-positive patient may respond to any one or to all of the manipulations listed in the table achieving a median response duration of up to 42 months. Thus ER information, which may only be available at the time of diagnosis, is critical to the subsequent management of the majority of patients with breast cancer.

Adjuvant Chemotherapy

Treatment of localized breast cancer with various forms of surgery and radiation therapy has been successful in the local control of the disease, but has not influenced the high mortality rate discussed above. Current attempts to decrease rates of distant spread and mortality are based on the treatment of clinically occult systemic metastases at the time of initial diagnosis. These clinically occult systemic metastases should contain fewer cells which are more actively proliferating and better vascularized than large tumor deposits and therefore more vulnerable to destruction by effective combinations of chemotherapeutic agents or by immunotherapy in a relatively immunologically intact host.

A prospectively randomized clinical trial carried out by Bonadonna et al.[2] has compajed the use of combination chemotherapy (cyclophosphamide, methotrexate, and 5-fluorouracil), given in monthly cycles for 12 months from the time of surgery, to no chemotherapy in over 400 women with Stage II breast cancer. At 36 months from the time of mastectomy, 26.3% of chemotherapeutically treated patients have relapsed as compared to 45.7% of untreated patients. However, closer scrutiny of these patients reveals that the benefit for chemotherapy patients is only seen in the premenopausal group. These results are similar to those reported by the National Surgical Adjuvant Breast Project[3] comparing single-agent chemotherapy (L-phenylalanine mustard) to placebo in Stage II breast cancer in which only premenopausal patients with fewer than four involved lymph nodes were benefited by two years of therapy (3.1% relapses at 24 months vs. 29.1% relapses in placebo group).

While the rationale for adjuvant systemic therapy in resectable breast cancer is sound, many questions remain. The seeming lack of efficacy of adjuvant chemotherapy in postmenopausal patients may suggest that the effects of chemotherapy in premenopausal patients are hormonally mediated (e.g., alkylating agent suppression of ovarian function). New directions in adjuvant studies include the use of hormonal manipulation in ER-positive patients, the use of immunotherapy, the use of different chemotherapeutic agents and combinations, the use of longer or shorter periods of therapy, and combinations of the above approaches.

An ER-negative patient would not be expected to respond to any of the hormonal manipulations and could therefore be spared unnecessary medical and surgical interventions.

Summary

The use of estrogen receptor assays and systemic adjuvant therapy represent two major new directions in breast cancer management. Every physician who has the responsibility for the diagnosis and treatment of breast cancer patients should be aware of the importance of obtaining tissue for estrogen receptors at the time of initial biopsy or mastectomy. Since only premenopausal women with ipsilateral lymph node involvement at the time of mastectomy have been shown to have prolongation of disease-free survival in the current adjuvant chemotherapy studies, such treatment remains experimental. The rationale for adjuvant systemic therapy is sound and many studies are under way to find the optimal form of adjuvant treatment. Primary physicians caring for patients with breast cancer are urged to participate in these ongoing clinical trials.

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Breast self-examination has the potential for helping more people to find their breast cancer earlier than any other method now available.

Breast Cancer in Georgia

Observations on 1,100 Cases Surveyed by the Georgia Cancer Management Network, Inc.

ROBERT L. BROWN, M.D., *Atlanta**

THIS OVERVIEW OF BREAST CANCER in Georgia is based upon a study by the Georgia Cancer Management Network, Inc., of 1,147 patients with breast cancer who were diagnosed between June 15, 1975, and June 15, 1977.

The Network at the time of this study was made up of 14 participating hospitals with a full-time oncology nurse coordinator and a part-time physician program director in each (see end of article for acknowledgements). The nurses engage in the collection of rather extensive data on each patient with breast cancer and in follow-up evaluation and support. They also teach women breast self-examination (BSE) and conduct training courses for instructors in BSE.

The methods of detection were studied. Seventy-eight percent of the breast cancers were found by the women themselves (58% accidentally and 20% by BSE). Examination by a physician was next (16%) and then mammography (5%). Breast self-examination was practiced at least once a year by 63% of the 1,147 women. A higher percentage of white women than black practiced BSE. Women learned how to do self-examination in different ways. The largest number (42%) were taught by physicians. Publications constituted the next largest source of knowledge of BSE (21.4%), then television (18%), American Cancer Society programs (7.8%), nurses (5.6%) and other sources (5.2%). For whites, publications were more important than TV. For blacks, TV reached more. Of the women who practiced BSE, 55% did so once a month, 11% every two months, 14% several times a year, and 20% once or twice a year.

The stage of breast cancer at time of diagnosis was recorded by the use of the International TNM System. The pathologic stage was used, since it includes microscopic findings in lymph nodes and distant sites. 75.4% of the women had International TNM Stage 0, I, or II. Stage 0 represents all cases with in-situ or non-invasive cancer (also designated as TIS). Stages 0, I and II are considered operable and relatively favorable. TNM Stage III includes patients with advanced local and/or regional disease, and Stage IV includes all cases which have distant metastases. Only 18.7% of the cancers were 2 cm or less in size and without metastases or fixation. Thus, *there is much more to be done if really early cancer is to be detected.*

When the method of detection was related to the pathological stage of disease, it became apparent that those patients who found their cancer by BSE found it while it was in an earlier stage than any other group except those in whom the cancer was detected by mammography (Table 1).

Breast self-examination had a direct relationship to the educational level of the patient. As years of education increased, the practice of BSE increased. Age also seemed to be an important factor in that more younger women practiced BSE, and they performed it more frequently. Furthermore, women at higher educational levels had earlier disease than did those with an elementary school education. When women who practiced BSE were compared with those who did not, and when this comparison was made within each educational category, it was obvious that self-examination itself made a significant difference and that it led to earlier diagnosis (Table 2). The beneficial effect of BSE was also evident within age groups.

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Another interesting and significant fact was that women who practiced breast self-examination, even though their cancer was actually discovered accidentally, by a physician, by mammography, or by other means, these women had breast cancer which was diagnosed in an earlier stage than did the women who did not practice BSE (Table 3). This difference was on the order of 20% and statistically is considered to be highly significant.

In our opinion, women who have taken the trouble to learn how to do BSE are a more discerning group. They may be more sensitive to a small lump or thickening so that even the accidental palpation of a change in the breast is more apt to register on their consciousness and lead to action. Breast self-examination is safe and without cost. It has the potential for helping more people to find their breast cancer early than any other method now available, and it is feasible for wide spread use.

The methods of treatment employed for primary breast cancer in Georgia as indicated by this study are shown in Table 4. Although modified radical mastectomy was used much more frequently for Stage 0 or I disease than was radical mastectomy, radical mastectomy was still the method of choice in Stages II and III. Radical mastectomy was employed somewhat more often than was modified radical for women under 70 years of age, but over 70 a much higher percentage were treated by the modified procedure or by simple mastectomy.

The stage of disease seen in Georgia during 1975-76 was compared with that recorded in 1973 by the Georgia Cancer Registry which covered many of the same hospitals now in the Network. It was apparent that there was an increase in the number of patients with cancer which had not extended beyond the breast (50.2% for 1975-76 vs. 40.6% for 1973). The use of modified radical for localized disease was found to have more than doubled and the use of radical mastectomy was down from 66% to 43%. When regional node metastases were present, although there was an increase in the use of modified radical, radical mastectomy remained the method of choice. Study of the use of adjuvant treatment in this series of patients revealed that chemotherapy was used as a supplement in 12.8% of the patients, radiation therapy in 12.6% and hormone therapy in a few patients, practically all of whom had advanced disease. Estrogen receptor assays were done in 15% of the patients and 59% of these were positive.

An important feature of this study was the attention paid to follow-up data. For Stage 0, I and II cases the relation of type of surgery to patient status was determined. At one year, 93% of those treated by radical mastectomy were alive and clinically free of cancer vs. 91% for modified radical. Arm function was actually a little better for patients treated by radical mastectomy than for those treated by modified radical. Flexion after radical was normal at one year in 85%, after modified radical 77%. Ab-

TABLE 1

METHOD OF DETECTION

	TNM Stages 0, I, II	TNM Stages III, IV
Self accidentally	73%	27%
Breast self-examination	82%	18%
Examination by physician	73%	27%
Mammography	93%	7%

TABLE 2

RELATION OF PRACTICE OF BSE TO STAGE OF DISEASE

	TNM Stages 0, I, II		TNM Stages III, IV		
	#	%	#	%	Total
BSE	603	83.2	122	16.8	725
No BSE	262	62.1	160	37.9	422
					1147

TABLE 3

PRACTICE OF BSE WITHIN EDUCATIONAL CATEGORIES

	TNM Stages 0, I, II
Elementary school	
BSE	67.7%
No BSE	54.2%
High school	
BSE	82.9%
No BSE	65.3%
College	
BSE	85.8%
No BSE	65.5%
Graduate school	
BSE	95.0%
No BSE	61.5%

TABLE 4

PRIMARY TREATMENT

	#	%
Radical mastectomy	487	42.6
Modified radical	503	44.1
Simple or total	89	7.7
Partial mastectomy	11	1.0
Subcutaneous mastectomy	2	0.2
Radiation	34	3.0
Hormone (additive)	12	1.1
Hormone (ablative)	1	0.1
Chemotherapy	2	0.2
	1141	

duction was normal at one year in 84% after radical, 74% after modified radical. As might be expected, post-operat ve swelling of the arm was slightly greater for those patients treated by radical mastectomy than for those who had modified radical (13.3% vs. 10.4%).

The adjustment of patients to their mastectomy was evaluated in a number of ways. Ninety-six percent were completely able to care for themselves at four months and 98% at one year. There was no difference related to the type of surgery. At four months, 96% had no pain or pain easily managed, and at one year 98%. Here again, no significant difference could be related to type of surgery. Ninety-five percent had no disturbance or minimal disturbance of sleep.

In this study, 78% of the breast cancers were found by the women themselves.

When return to work, homemaking, school, or retirement activity were considered, 72% were found to have resumed all prior responsibility at four months, and 86% at one year. An additional 24% had partial resumption at four months and 11% at one year. The figures for each type of surgery varied by no more than one or two percent. Earning capacity was unchanged or improved in 83% at four months and 88% at one year. It was reduced but not a problem in another 13% at four months and 9% at one year.

The type of surgery did not influence use of breast prosthesis. Fifty-nine percent had a satisfactory prosthesis at four months and 70% at one year. Five percent reported the prosthesis unsatisfactory, one percent did not wear a prosthesis because of medical reasons, eight percent because of financial reasons, and 14% because of personal preference.

Summary

Seventy-eight percent of breast cancer was found by the patients themselves (58% accidentally, 20% by breast self-examination). Sixty-three percent of the women in this study practiced BSE and of these 83% had breast cancer in the relatively favorable stages TNM 0, I or II, whereas only 62% of women who did not practice BSE had breast cancer in these stages.

Physicians were the chief source of instruction in BSE, but significant numbers of women learned from TV and publications. The higher the educational level, the more frequent the practice of BSE and the earlier the stage of disease. The value of BSE was evident at all educational levels. More women under 50 than over 50 practiced BSE and they practiced it more often. BSE was of value in all age groups.

There has been a trend away from radical mastectomy for Stages 0, and I breast cancer, but in this group of patients it was still the preferred treatment for TNM Stages II and III. Breast cancer was diagnosed earlier in 1975-76 than it was in 1973.

The adjustment to mastectomy as measured by several parameters is very good for most women. It is not significantly influenced by the type of operative procedure.

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Careful explanation and reassurance to the patient are essential factors in any therapeutic regimen.

Peyronie's Disease

DONALD J. McKENZIE, M.D., *Thomasville

SINGLE OR MULTIPLE AREAS of induration occurring along the dorsum of the shaft of the penis in association with deformity of the erect penis was initially described by Francisura de la Peyronie in 1743. Since that time, many articles describing the fibrous plaques in the sheaths or intercavernous septum of the corpora cavernosa have appeared in the literature. At least two additional names have been offered for the disease including Van Buren and even Dupuytren of palmar fascia contracture fame. The latter name apparently became associated with the disease when striking similarities were noted with regards to the occurrence in the same patient of palmar fascia contracture and the fibrous plaques occurring on the dorsum of the penis.[1-4] There is no current evidence to indicate that the two entities are related and, over the years, the name of Peyronie has been ensconced in the medical literature in describing this particular syndrome.[6]

Diagnosis of this entity is usually made by the palpation of the typically irregular, firm area or areas along the dorsum of the penis, together with the patient's history of deformity with regards to angulation at the time of erection. Diagnosis is usually not carried to the point of biopsy, but should this occur, microscopically, keloid-like lesions typified by an absence of inflammatory changes with occasional deposits of calcium have been noted.[4] Biopsy of the plaques has not been established as a necessary criteria for the diagnosis in the literature. Although many hypotheses have been advanded regarding the etiology of Peyronie's Disease, including sexual behavior, the association of other connective disease processes in the same patient, and the possible association of an unknown viral urethritis, are among a few of the possible etiologic agents mentioned in the literature.[5]

Treatment

The modes of treatment of Peyronie's Disease exhibit a unique and at times highly imaginative approach to a quite difficult problem. Direct surgical excision has been used, but it is not currently considered a primary mode of therapy. Irradiation of the plaques has been used with little success. Systemic agents such as vitamin E and potassium para-aminobenzoate have been used in almost massive dosages with questionable success.[6] Direct injection of the plaques with steroidal preparations may temporarily relieve the discomfort associated with erection in the area of the plaque, but sufficient evidence is not available to indicate that local injection of steroids is curative. Direct surgical exposure of the plaques utilizing semi-micro surgical techniques and

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saturation of the plaques with corticosteroids via dermo-jet microspray injectors have been employed recently.[7] Although initial results from this procedure seem encouraging, the very nature of Peyronie's Disease will require long-term followup in order to adequately evaluate it.[12]

Many individuals extensively reviewing the literature and presenting their own work conclude:

1) The pain of Peyronie's Disease will frequently subside spontaneously with no treatment and regardless of the treatment.

2) Whatever treatment is used, whether radiation, cortisone, injection or systemic agents such as potassium para-aminobenzoate, judicious dosages so as not to cause local deformity or systemic symptoms are a paramount consideration.

In an analysis of approximately 250 patients in which various modes of therapy were employed, it was concluded generally that:

1) Most individuals are somewhat unwilling to wait the average length of time, some four years, for the disease to subside spontaneously to a rather regressed point.

2) The cytostatic drug procarbazine (Natulan) was somewhat efficacious, but also possessed moderate side effects.[8, 9]

3) The judicious use of either local or systemic steroids together with vitamin E seem to shorten the longevity of the basic plaque existence together with the penile deformity.

4) Historically, the most common drug employed in therapy is potassium para-aminobenzoate.[10] The exact mechanism of the drug is unknown, although rather imaginative descriptions of its mode of action have been offered. It is important to realize that sulfonamides are direct antagonists of this drug and should not be administered concurrently.

5) The multiple therapeutic modalities offered in the literature has led at least one author to list many of these and rate each one according to its potential harm or benefit to the patient. It is most interesting that the therapeutic modality listed to be least harmful or most likely to be beneficial, and felt to be entirely safe, would be observation alone with psychological support.

At this time, no one single therapeutic modality stands out as being clearly superior to all other methods employed.[6]

Summary

The only universally accepted characteristic of Peyronie's Disease reported in the literature, is the histologic characteristic of the fibrinous plaque occurring along the dorsum of the penis. Therapeutic modalities vary widely and no one approach to therapy at this time stands out as clearly superior to all others. In establishing an approach to treating this problem, it is essential initially to accurately document the location and extent of the plaques, the extent of discomfort associated with angulation on erection as described by the patient, and some appraisal of the degree of the patient's anxiety or concern over the problem. A careful explanation to the patient of the nature of the disease is essential. Although the physician may at times feel a need to "do something," in many cases, the better part of valor may be observation.

Current series of cases being reported in the literature may indicate some promising results from the direct application of steroids to the plaques. Some 234 years after the initial report in the literature on Peyronie's Disease, the most outstanding characteristics are:

1) Etiology is obscure;

2) The histologic plaques have been carefully studied and well documented;

3) No single therapeutic regimen presents as the definitive treatment at this time;[11, 12]

4) Careful explanation and reassurance to the patient are essential factors in any therapeutic regimen.

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Breast Cancer: Diagnosis and Management

IN THE FALL OF 1977, the Georgia Radiological Society, in conjunction with the Georgia Surgical Society, presented a course at the MAG meeting on "Cancer of the Breast: Diagnosis and Management." Fifteen excellent papers were presented. Because of the timeliness of the topic and the excellence of the papers, I asked our MAG *Journal* editor, Edgar Woody Jr., M.D., if he would devote an issue of the *Journal* to the breast. He shared my interest!

So five of the papers are published in this issue. One tells us of the benefit of mammography, two are concerned with identifying the women most likely to develop breast cancer, another tells us of hormonal and chemical therapy and which patients will benefit from it, and the final paper is a survey article telling us how patients with breast cancer are detected and managed in Georgia.

In the lead article, Jerry B. Buchanan, M.D., discusses the risk versus the benefit of mammography, concisely putting into perspective the hypothetical risk involved. He states that mammography alone is the most sensitive indicator of occult breast cancer, that the benefit of mammography in the early detection of clinically occult lesions may well be life itself.

Marjorie B. McSweeney, M.D., authors the paper, "Breast Parenchymal Patterns as an Indicator of Risk for Developing Breast Cancer." Mammographers wish they were able to look at a particular breast and say, "This breast has a ten percent chance of developing cancer in three years, but this one has a seventy-five percent chance." Should such a risk pattern be established, follow-up of the higher risk group could be more concentrated. Dr. McSweeney reports the work of another mammographer (Wolfe) and his attempt to classify breast parenchymal patterns into four categories, each at different risk. The Wolfe classification was then applied to 6,000 patient mammograms at Emory. The results of this study are surprising. To steal a bit of her thunder, one might suggest that the easier it is to see a cancer (a tiny lesion in a fatty breast), the easier it is to diagnose; and the more difficult it is to see a cancer (a tiny lesion in a dense, glandular breast), the more likely the lesion will be obscured and go undetected. Which population would you monitor more closely?

Dr. Robert L. Egan, one of the country's foremost mammographers, is concerned with the early identification of women at an increased risk of developing breast cancer and presents his approach in his article, "Detection of Breast Cancer: Contribution of High Risk Factors." Dr. Egan envisions a predictive procedure to identify the six percent of the female population who will eventually develop breast cancer. He has developed a prospective study utilizing epidemiologic, clinical, and mammographic factors, slapped the various parameters on each patient into a computer, and subjected the print-out to a statistical analysis—all in an effort to isolate the female population at greatest risk of developing breast cancer. This population would then be

subjected to the closest possible follow-up for the mammographic detection of clinically occult lesions.

Dr. Melvin R. Moore, an oncologist, writes on, "Breast Cancer—New Directions." He looks on *clinically apparent* breast cancer as a systemic disease. He tells us of the Estrogen Receptor (everyone knows what that is!) protein and explains why it is necessary to have Estrogen Receptor assays on all breast cancer tissue at the time of initial biopsy. We are told which patients will benefit from hormonal therapy and which patients will benefit from chemotherapy.

Dr. Robert L. Brown, a retired cancer surgeon, medical clinic administrator, and currently, Clinical Programs Coordinator of the Georgia Cancer Management Network, surveys 1,100 cases of breast cancer in Georgia and tells us how these patients' tumors are discovered and how they are managed. Seventy-eight percent of the women discover their own cancers. Only sixteen percent are discovered by a physician. And mammography accounts for but five percent. So most breast cancers when clinically detected are already advanced; therefore, early detection of the occult lesion, by whatever modality, is an urgent need.

Although Dr. Moore encourages Estrogen Receptor assays on all breast cancer tissue at the time of initial biopsy, Dr. Brown tells us that this test is currently performed on only fifteen percent of the patients throughout the state. The survey also indicates a trend away from radical mastectomy.

In their papers, these concerned physicians speak of the ideal, while showing us the actual and tantalizing us with the carrot of betterment in our management of the 90,000 new cases of breast cancer detected each year.

Stewart R. Roberts Jr., M.D.
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president's letter



(Editor's note: This month's letter is excerpted from a speech Dr. Burgstiner gave before med students at MCG. As you'll see, the advice holds for practicing physicians as well as students.)

Advice to Students of Medicine

WHETHER A FIRST YEAR freshman or a 50-year veteran practitioner, I want to extend to each of you my deep felt congratulations. You are very special people. You made a special effort to become a physician and will do a special job wherever you are. Medicine is that kind of avocation, and I am very proud of you and wish you every success.

I would like to speak about several personal attributes with no special concern for the commonplace virtues, with particular emphasis on a few less often mentioned but especially valuable qualities. I beg you sometimes to be unreasonable. The unreasonable man persists in trying to shape the world to himself. Therefore, most progress depends on the unreasonable man. So often, however, this involvement requires the courage to be heard, the courage to take a stand, the courage to avoid the role of bystander, though the issue be unpopular, though appeasement is easy, though silence is expedient. Oftimes the appearance of courage is as important as the substance of courage.

Resolve to make no small plans. They will spare no one, least of all yourself, and your world will be diminished accordingly. Far better it is to form big plans, exciting plans, plans with a vision, and even though risks there may be, accept them gracefully. To dare splendid things, you will certainly court failure, but how much better that, than to dwell in a twilight that knows neither victory nor defeat.

Reach always for the best there is. Few of us achieve the levels of excellence of which we are capable. So much there is to see and do along the way. There is so much applause for second and third rate achievement, that to settle for mediocrity is all too easy. Sooner or later, however, humanity turns to excellence as naturally as a flower turns to the sun. Socrates was executed; Christ was crucified. But in the end, they received the homage of the world.

Choose carefully your friends and value them highly. The size of a friend can be measured by the size of the circles he draws to take the world in. Some of us are too small to draw a circle much larger than ourselves, but others of us are wiser and stronger and build enormous circles, which are filled with warmth and life and love and all manner of friends.

If you will, try to listen more and talk less. One learns nothing by talking, and only you who listen have something worthwhile to say. At the same time, be sparing with advice: The wise don't need it, and others won't listen.

Enjoy your own company beyond that of others. Nowhere will you find a

quieter or more untroubled haven than within yourself. Knowledge of yourself is the only real wealth there is, and from it comes strength and peace and self confidence. Self confidence may not always get a person to the top, but no one ever got there without it. Strive unceasingly to be a futurist, living each day as it comes, as grand, as long as it includes planning for tomorrow. Surprises tend to be unpleasant and unproductive, and their shock can generally be avoided by anticipation.

Lastly, human life is a brief golden span between two oblivions. Starting as a miracle and ending in mystery, in between are varying degrees of happiness and frustration, of fulfillment and anxiety, and of joy and pain. To each of you has been given the unique privilege of lifelong service to the betterment of the human condition. In the words of Oliver Wendell Holmes, "To cure seldom, to relieve often, but to comfort always, this is your challenge."

Sincerely,



Carson B. Burgstiner, M.D.
President, MAG

I've told this before . . .

(Editor's note: Dr. Kellum shares a "shaggy elephant" story which will especially be appreciated by fans(?) of a certain engineering institution. Others wishing to contribute to this page are invited to send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

And the King Drank His Whiskey, Clear

KING GEORGE III's tax collectors reported to him that hardly anyone was paying their taxes. Many things had been tried, but to no avail. After a lengthy session, they decided to build a huge torture rack. So, they sent for the best teakwood from India and large stone wheels from Rome. A giant wagon was thus made for the rack, that could torture 50 delinquent taxpayers at one time. The wagon and its rack was now placed in the center of London, and in a few days, they had an excellent response from the Londoners, but none from the rest of the empire. So they decided to carry it from city to city.

Eight large elephants and a trained elephant driver were obtained from Siam. As they approached Manchester, the town crier announced in amazement, "Here comes the rambling rack, for George's tax, and an elephant engineer!"

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heart page
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Valve Disease: Clinical Recognition and Assessment of When to Operate

ARTHUR J. MERRILL JR., M.D., *Atlanta**

In the last decade, new non-invasive methods such as echocardiography and nuclear scanning have been used to try to improve the diagnosis and management of patients with valve disease and other forms of heart disease. Echocardiography has certainly helped in the diagnosis of mitral valve prolapse (click murmur syndrome) and mitral stenosis. In spite of these methods, the recognition of all valve disease depends on the astute clinician. The severity of aortic stenosis, aortic insufficiency, mitral stenosis and mitral insufficiency can also generally be estimated from physical exam, electrocardiogram and chest x-ray.

Why is early recognition of valve disease important? Coronary disease, poor pre-operative myocardial function, and in the case of mitral valve replacement severe pre-operative pulmonary hypertension are the main cause of operative deaths.[1, 2] Recent long-term follow-up of patients surviving valve replacement has shown that these same problems (coronary disease, myocardial function and pre-operative pulmonary hypertension) are major causes of late deaths also.[2, 3, 4] Endocarditis and valve malfunction are much less common today than ten years ago and cause problems in only a small percentage of patients.[2] Thanks to newer valves, e.g., porcine heterograft, Bjork Shiley valve; and more careful anti-coagulation of patients with older valves, thromboembolism is also less common[2] (as low as 1-2% in some series).[5, 6] Coronary disease is now treated surgically at the same time as valve replacement, with little increase in operative mortality. Even though asymptomatic, coronary disease is now identified at catheterization because almost

* Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

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all patients being evaluated for surgery have catheterization and coronary angiography prior to operation. Because of this and improved myocardial preservation techniques and postoperative care, aortic mitral valve replacement can be done in most good centers with an operative mortality of 6% or less. Clinicians, in most cases internists and general practitioners, then must recognize and refer patients with valvular disease before myocardial damage or pulmonary hypertension is irreversible.

How can a physician recognize patients before myocardial deterioration occurs? For each valvular lesion there are certain clinical findings that suggest its presence or predicted severity.

Mitral Stenosis

In any patient, particularly a woman, with dyspnea, unusual fatigue, hemoptysis or atrial fibrillation, a loud first heart sound (particularly one that is palpable) should alert one to look for mitral stenosis. If the diastolic rumble cannot be heard at the apex with the patient on his left side, some situps or amyl nitrite may bring it out. If the patient has a vertical axis on EKG or an R prime in V-1, he or she may have pulmonary hypertension. When Kerley B lines (horizontal linear densities in the outer lower lobes) are seen on chest x-ray, left atrial pressure is 25 or over, and the patient probably needs surgery soon.[7] Echocardiography can confirm the diagnosis. Surgery generally is done now when the patient has enough symptoms to interfere with normal daily activity (N.Y. Heart Association Class II-Class III).

Aortic Stenosis

The murmur of the aortic stenosis is generally easy to hear but many middle-aged men and women have a systolic ejection murmur. Patients with a Grade II or more systolic murmur and angina, congestive failure or syncope should be evaluated for aortic stenosis. If the severity cannot be assessed clinically, they probably need to have cardiac catheterization to measure the gradient across the valve. The mean survival of patients with aortic stenosis after development of the above symptoms is less than five years.[8] If there's a systolic thrill in the upper precordium or right carotid associated with the murmur, the patient probably has significant stenosis. In the absence of hypertension or coronary disease, an S-4 gallop usually means significant aortic stenosis (a gradient of more than 50 mms) if the patient is less than 60 years old. Calcium in the aortic valve should be looked for on lateral chest x-ray or cardiac fluoroscopy; if present in patients less than 60 years old, it generally indicates significant aortic stenosis. In patients over 60 years old both an S-4 and calcium in the valve are often present without significant stenosis. The heart size is usually normal on chest x-ray in pure aortic stenosis. The EKG may not show left ventricular hypertrophy so is helpful only if left ventricular hypertrophy is present. If there is doubt about the significance of the stenosis in patients with the above symptoms, they should be referred for further evaluation, because long-term results following aortic valve replacement for aortic stenosis are excellent.[2]

Aortic Insufficiency

The murmur of aortic insufficiency is high pitched and can be difficult to hear. Significant aortic insufficiency should be suspected in any patient with a pulse pressure of greater than 60-70 mmHg.[9] One usually finds a bounding carotid, a systolic ejection murmur in the right second intercostal space, and often a pistol shot sound over the femoral arteries. The murmur should be searched for by having the patient sit up, lean forward and exhale. It is usually loudest along the left sternal border. Once a patient with aortic insufficiency is identified, he or she should be followed closely to look for increase in heart size by x-ray and for increasing left ventricular hypertrophy with strain by EKG. Either of these findings suggest the ventricle is not compensating well and the patient probably needs aortic valve

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BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

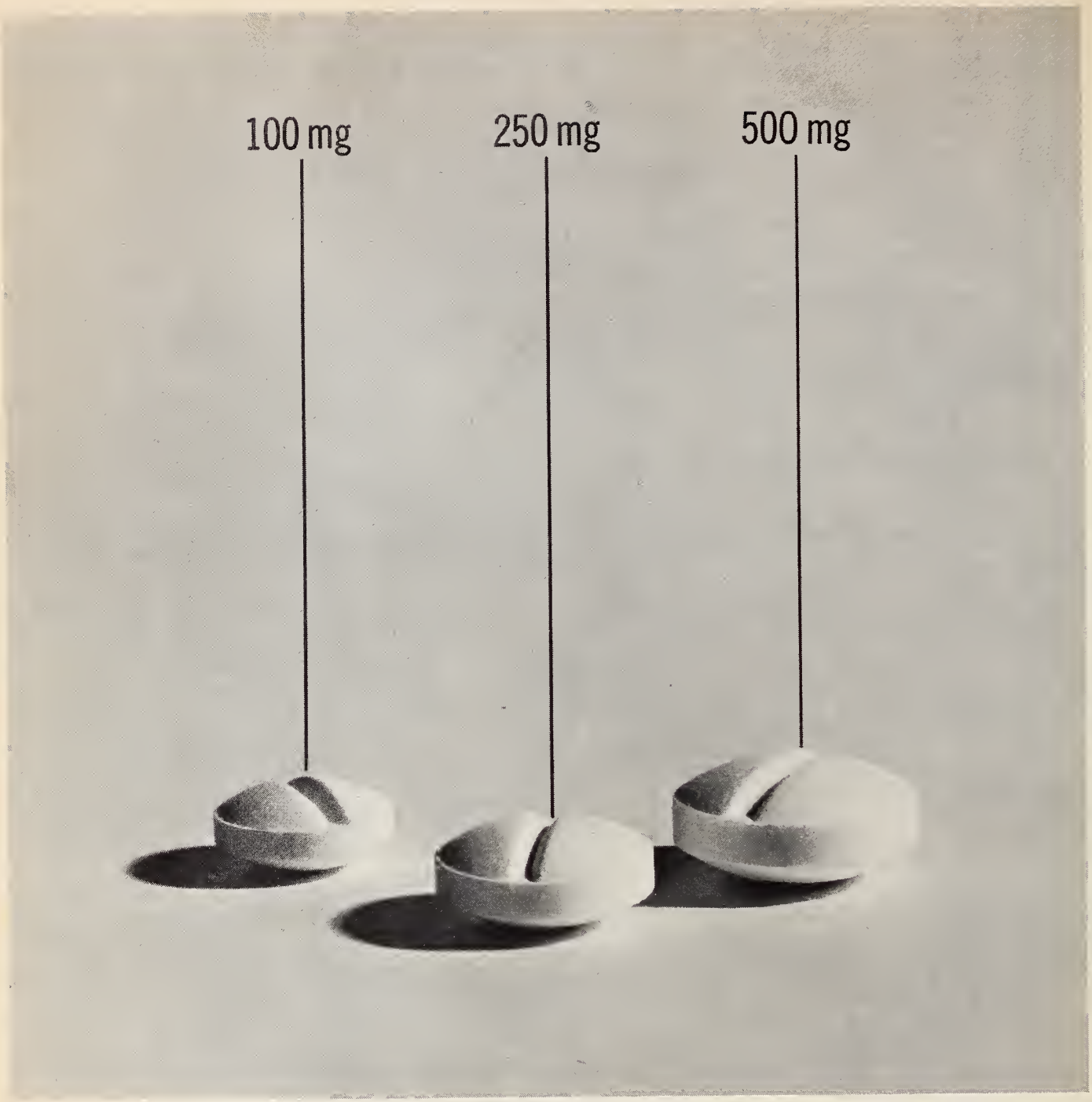
In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

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replacement. Unoperated, patients with these findings have a 50% five year mortality.[9]

In addition, if the heart size does not decrease postoperatively, the five year mortality after successful valve replacement is over 50%.[4] If the patient develops angina, congestive failure (even if controlled by digitalis drugs) or syncope, operation is also indicated but myocardial damage may be irreversible.

Mitral Regurgitation

The murmur of mitral regurgitation is often difficult to distinguish from aortic stenosis except that the former decreases with amyl nitrite while the latter gets louder. The presence of an S-4 in patients with mitral regurgitation suggests recent worsening in the absence of coronary disease and hypertension. A long low pitched apical S-3 and a late systolic parasternal lift indicate significant mitral regurgitation. If a patient has increasing fatigue or exertional dyspnea and a mitral systolic murmur, surgerv may be indicated if he has left ventricular hypertrophy on EKG or cardiomegaly on x-ray. Patients with mitral regurgitation may remain asymptomatic for a very long time, but, if their hearts get too big, the damage to the heart muscle does not reverse with surgery and they may have a high operative mortality and poor prognosis postoperatively.[1]

Summary

The improvement in operative time, artificial valves and myocardial preservation during open heart surgery have all contributed to lower operative mortality. Most operative deaths are now due to myocardial failure. Since most long term deaths following valve replacement have also been due to myocardial failure or coronary disease, physicians must recognize the severe valve lesions and refer patients with these lesions for earlier evaluation and consideration for surgery—usually when they become AHA clinical class II or develop the physical findings cited above. Sometimes these findings are subtle, but cardiac enlargement or EKG evidence of LVH in the absence of hypertension usually mean the patient should be referred for more extensive evaluation. Only in this way can the longterm prognosis following valve replacement be improved.

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Individual Practice Associations

ROBERT N. BERG, *Atlanta**

In recent years, a popular topic of discussion among persons both in and associated with the medical profession has been the concept of "Individual Practice Associations" ("IPAs"). Concomitant with this popularity, however, a considerable amount of confusion has developed as to the nature and functions of IPAs. To alleviate some of this confusion, this article will outline: (1) the statutory requisites for establishing an IPA; (2) the services provided by an IPA, and (3) the potential advantages of establishing an IPA.

What Is an IPA?

The Health Maintenance Organization Act of 1973,[1] as amended,[2] (the "Act"), was enacted for the purpose of making "available to all Americans a real choice with respect to the form of medical delivery they individually wish to purchase"[3] by fostering the development of Health Maintenance Organizations ("HMOs") throughout the nation. Once established, these HMOs provide for a wide range of medical services, including medical, dental and other health services, to a defined population of voluntary "enrollees" for a predetermined, prepaid premium; this premium, unlike the traditional fee-for-service payments, is normally not directly related to the quantity of medical services received by any particular enrollee.

Pursuant to the Act, an HMO may opt to provide its enrollees with medical services in one of four ways or any combination thereof. An HMO may elect to provide its enrollees with medical services through health professionals who are members of the staff of the HMO; secondly, an HMO may choose to "contract out" the provision of medical services to health professionals who are not associated with the HMO. Additionally, an HMO may elect to provide services through a

* Prepared at the request of The Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

''medical group''; this group is defined in the Act as a partnership, association or other group of health professionals (a majority of whom are licensed physicians or osteopaths) who, among other things, have, as their primary purpose, substantial responsibility for the delivery of health services to members of an HMO, who pool their income from their practice as group members and distribute this income pursuant to a prearranged salary or other plan, and who are required to share medical records and substantial portions of major equipment and professional, technical and administrative staff.[4]

The final method which an HMO may select to provide its enrollees with medical services is through an IPA. Pursuant to the Act, an IPA must be a partnership, association or other legal entity which has entered into a services arrangement with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health professions.[5] This arrangement must provide (1) that the members of the IPA shall provide health services in accordance with a compensation arrangement established by the IPA; and (2) to the extent feasible, for both the sharing of medical records, equipment and staff, and the arrangement and encouragement of the continuing education of the IPA members in the field of clinical medicine and in related areas.[6]

What Services Does an HMO Provide?

An HMO is responsible, through one or more of the methods described above, for providing ''basic health services'' to its enrollees; in addition, an HMO may opt to provide its enrollees with ''supplemental health service.'' Pursuant to the Act, ''basic health services'' is defined to include: physician services (including consultant and referral services); inpatient and outpatient hospital services; medically necessary emergency health services; short-term, outpatient evaluation and crisis intervention mental health services; alcohol and drug abuse treatment and referral services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; and preventive health services.[7]

In addition to the provision of these ''basic health services,'' an HMO may opt to provide its enrollees with ''supplemental health services.'' These services are defined to include: services of facilities for intermediate and long-term care; vision care; dental services; certain mental health services; long-term physical medicine and rehabilitative services (including physical therapy), and the provision of prescriptive drugs prescribed in the course of the provision of basic health services.[8]

What Are the Advantages of Establishing an IPA?

Support for the establishment of HMOs is based on the fact that the provision of medical services by HMOs purportedly offers several advantages over the traditional fee-for-service system. For example, it is said that the provision of these services by an HMO through an IPA, either alone or in conjunction with the other methods discussed above, would, at least in theory, result in lower hospital utilization, lower costs, continuity of care, greater accessibility to and use of primary medical care, and greater satisfaction with medical care received.[9] Moreover, the establishment of an IPA would, in most cases, involve lower capital requirements than the ''staff'' or ''medical group'' models discussed above, in that most IPA's will utilize already existing facilities.

The establishment of IPAs could also generate substantial benefits in connection with the provision of medical services to government employees and employees of large companies. Pursuant to the Act, certain employers, including those who employ an average of not less than 25 employees, and state governments or political subdivisions which employ not less than 25 employees, are required to offer each employee the option of becoming an enrollee in a qualified HMO, if one is providing medical services to residents in the area.[10] In that context, the establishment of a ''network'' of IPAs, similar to the network concept presently being utilized under the direction of the Civil Service Commission[11] to provide health benefits to federal employees, could result in an efficient method of providing

medical services in more than one geographic area (e.g. to all employees of a major national corporation).[12]

Notes

1. P.L. 93-222, December 29, 1973.
2. The Act was amended by the Health Maintenance Organization Amendments of 1976, P.L. 94-460, October 8, 1976.
3. Senate Report No. 93-129. April 27, 1973.
4. For a more comprehensive look at HMO's, see Killingsworth, "Federal Health Maintenance Organization Amendments of 1976," Journal of The Medical Association of Georgia, April, 1977, pp. 237-241.
5. Pursuant to the Act, a majority of the IPA members must be licensed physicians and osteopaths.
6. 42 U.S.C. §300e-1(c).
7. 42 U.S.C. §300e-1(1).
8. 42 U.S.C. §300e-1(2).
9. Cf. Gaus, Cooper and Hirschman, "Contrasts in HMO and Fee-for-Service Performance," Office of Research and Statistics, Social Security Administration, 1975.
10. Pursuant to 42 U.S.C. §300e-9, if more than one HMO is engaged in the provision of medical services in an area, and, of these HMO's, one or more provide these services through an IPA, and one or more provide these services through some other method, the employer will be required to offer at least two alternative health benefits plans, with at least one plan utilizing the services provided through the IPA, and with at least one plan utilizing the services provided through some other method.
11. See 5 C.F.R. §890.101 *et seq.*
12. A proposal for the establishment of a network of IPA's in California and certain other states has recently been submitted to the Department of Health, Education and Welfare by the American Association of Foundations for Medical Care.

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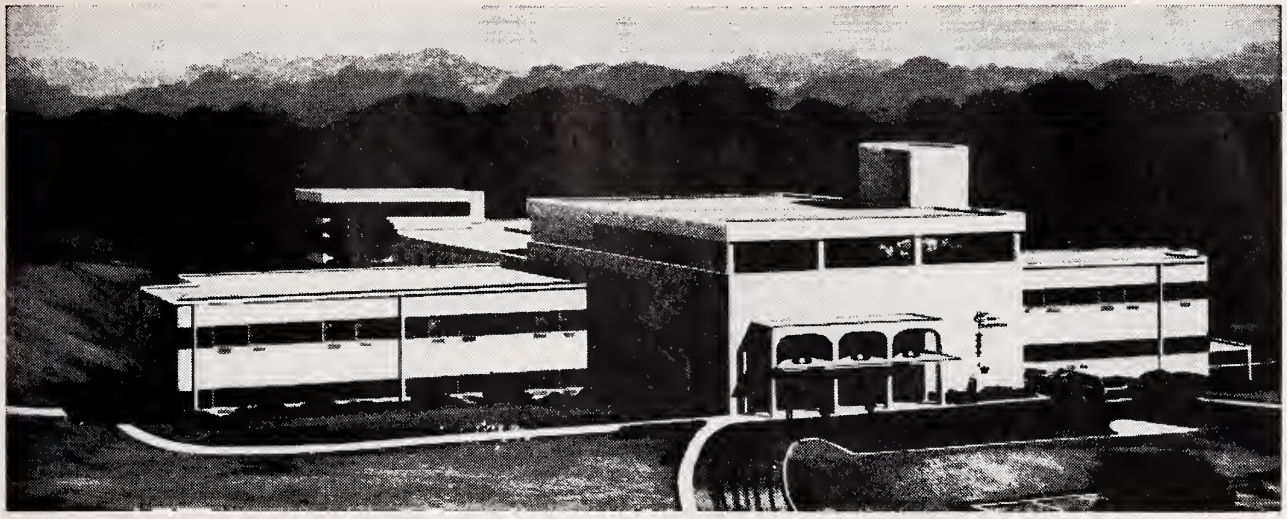
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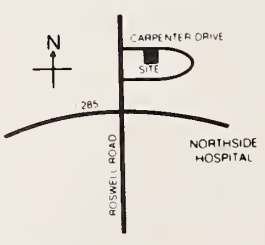
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SOCIETIES

The **DeKalb County Medical Society** held its annual joint meeting with the DeKalb Bar Association in March. Guest speaker at the event was the president of the American Bar Association, William B. Spann Jr.

The March meeting of the **Muscogee County Medical Society** was a joint meeting with the Columbus Lawyers Club. In April, the Society heard a talk by Sister Jane M. Gates, M.D., of Lumpkin, who spoke on her experiences as a medical missionary in Uganda.

PERSONALS

Second District

The American Board of Family Practice has named **Harmer O. Eason Jr., M.D.,** of Sylvester, and **James Hexie Stone, M.D.,** of Moultrie, diplomates.

William King, M.D., Tifton, discussed advances in obstetrics and their significance for women during a recent program at Alpha Delta Chapter of Beta Sigma Phi sorority. Dr. King is a partner in Tifton Woman's Clinic.

Third District

Mary Schley, M.D., Columbus, has been named chairman of the Medical Center Hospital Authority. She has been a member of the board since it became an authority in 1976. Her new duties will begin July 1.

The first of a five-part series called "Women and Their Special Needs" took place recently at Columbus College. Featured speaker was **Micki Souma, M.D.,** who spoke on "Menarche to Menopause: Physiological and Psychological Stress."

Frank Vinson, M.D., Ft. Valley, was presented a plaque by the Peach Belt Medical Auxiliary on Doctor's Day "for professional and community service since 1933."

Columbus physician **John D. Watson Jr., M.D.,** was installed as president of the American College of Nuclear Medicine at its annual business meeting in April.

Fourth District

James E. Anthony, M.D., medical director of the Division of Vocational Rehabilitation, Georgia Department of Human Resources, had been named state medical coordinator. In this position, starting July 1, he will provide medical expertise for investigations of doctors around the state and for other programs relating to medical licensing and discipline. Dr. Anthony was once president of the State Board of Medical Examiners and has served as chief of surgery at both Decatur Hospital and DeKalb General Hospital. He was president of the DeKalb County Medical Society in 1964-65.

Villa Rica physician, **James Franklin Green, M.D.,**

has been named a diplomate of the American Board of Family Practice.

The Julius McCurdy Citizenship Award for 1977 was presented to **Ralph A. Tillman, M.D.,** by Decatur Federal Savings and Loan Association. The award goes to members of the medical profession for outstanding accomplishments outside their regular practices. Dr. Tillman has served two years as chief of the Ob-Gyn staff at DeKalb General Hospital and he and his wife have built and maintained a youth camp in Pickens County.

Fifth District

Joseph B. Baird, M.D., has been elected to a two-year term as director of the medical staff at Peachtree and Parkwood Mental Health Center and Hospitals.

Southwest Community Hospital's medical staff has elected **Juel Pate Borders, M.D.,** as president for 1978-79. An Atlanta Ob-Gyn specialist, Dr. Borders is the first woman to hold this office in the history of the hospital.

F. Phinizy Calhoun Jr., M.D., a professor and chairman of Emory's Department of Ophthalmology, was honored with the annual Medical Alumni Association Award of Honor at the annual Medical Alumni dinner dance.

Robert D. Rockfeld, M.D., Roswell, was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the group's annual meeting in Dallas.

Seventh District

At the American Academy of Orthopaedic Surgeons' annual meeting, **Stephen Bethea, M.D.,** and four other authors presented a paper on "Traumatic Fractures around Total Hip Arthroplasties—Open or Closed Treatment, 30 Cases."

Also at that meeting, **Alfred O. Colquitt III, M.D.,** and **David L. Ebersbach, M.D.,** were inducted as fellows of the Academy.

M. Victor Dardin, M.D. and **David M. Nowell, M.D.,** Dalton, and **G. B. Espy, M.D.,** and **P. Robert Mitchell, M.D.,** of Marietta, have been re-certified as diplomates of the American Board of Obstetrics and Gynecology.

The American Association for Hand Surgery has appointed **Gordon N. Gerson, M.D.,** chairman of the Commercial Exhibits Committee for its annual meeting.

Maury Claiborne Newton Jr., M.D., has been named a diplomate of the Cardiovascular Specialty Board of the American Board of Internal Medicine.

The Georgia Society of Plastic Surgeons has named **Benjamin H. Wofford, M.D.,** president. New treasurer for the group is **Michael Feinerman, M.D.** and its representative to MAG's Interspecialty Council is **Anthony Musarra II, M.D.**

Eighth District

Valdosta physician **Bill Grow, M.D.,** recently spoke on the late complications of diabetes at a meeting of the Lowndes Diabetes Association.

"Are We Getting Anywhere with Cancer?" was the topic of the kick-off meeting of the Cook Cancer Unit's Cancer Crusade. The featured speaker was **James Mathis, M.D.,** Valdosta, who spoke on the importance of early detection in the treatment of cancer victims.

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Ninth District

Gainesville physicians **John K. Burns III, M.D., Henry S. Jennings, M.D., W. D. Stribling III, M.D.** and **Jackson W. Thompson, M.D.,** have been recertified as diplomates by the American Board of Internal Medicine.

John White Garland III, M.D., Gainesville, has been named Man of the Year by the Georgia Psychiatric Association. A past president of the Hall County Medical Society, he was recognized for his work on the association's legislative committee.

Richard J. Turner, M.D., has completed requirements to retain active membership in the American Academy of Family Physicians.

Tenth District

Augusta physician **Fredrick C. House, M.D.,** assistant clinical professor of medicine of the attending staff of University Hospital, has been elected to fellowship in the American Academy of Allergy.

The Richmond County Grand Jury has appointed **Kenneth McDonald, M.D.,** to a position on the Richmond County Board of Health, to fill an unexpired term. Dr. McDonald is a former president of the Richmond County Medical Society and former chairman of the Mental Health Committee of the State Board of Health.

DEATHS

Yasuyuki Akamatsu

Yasuyuki Akamatsu, M.D., Ph.D., Augusta, assistant professor of pathology at the Medical College of Georgia, died March 21, 1978.

Dr. Akamatsu did cancer research sponsored by the Rockefeller Foundation and American Cancer Society at Rochester University. He also had held pathology positions at the University of California in Los Angeles and at the Atomic Bomb Casualty Commission on Hiroshima before establishing an experimental cancer laboratory at Osaka University in Japan. He joined MCG in 1968.

Survivors include his wife, Noriko Maki Akamatsu, Augusta; two daughters; one son.

John J. Farris

Bartow physician John J. Farris, M.D., died April 15, 1978, at the age of 55.

A native of Bartow, Dr. Farris had practiced medicine in Bartow and Wadley for 27 years. He was a retired U.S. Army captain, a veteran of World War II and a graduate of Emory University School of Medicine. He was a former member of the Jefferson County Board of Education.

Survivors include his wife, Sara Frances Jones Farris; three sons; his mother.

Franklin H. Goodwin

Franklin H. Goodwin, M.D., Dublin, died March 5, 1978, at the age of 68.

A native of Louisa, Virginia, and a veteran of World War II, Dr. Goodwin had lived and practiced in Dublin for 16 years. He was a graduate of Virginia Military Institute and the Medical College of Virginia and had practiced medicine in Atlanta for 17 years at the Berry-Goodwin-Bennett Clinic.

Survivors include his wife, Virginia "Betsy" M.

Goodwin, Dublin; a son; a daughter; two brothers; a sister; four grandchildren.

Albert Sidney Johnson Sr.

Retired physician Albert Sidney Johnson Sr., M.D., died April 27, 1978, at the age of 89.

Born in Hall County, he had lived in Elberton for the last 65 years. He served on the Elberton City Council and in the Georgia General Assembly and was a director in the Elberton Federal Savings and Loan Association.

Survivors include one son, A. S. Johnson Jr., M.D., Hilton Head, S.C.; two daughters; one sister; one half-sister; nine grandchildren; six great-grandchildren.

MAG HONORS HIGH SCHOOL STUDENTS

Three Atlanta-area high school students received top honors in the medicine and health category at the recent Georgia Science and Engineering Fair in Athens. The fair was a complete success, attracting a record 575 exhibitors and 460 visitors. The MAG awarded savings bonds to: Elizabeth McDowell, Dunwoody, first prize for "An Investigation of Association in Human Chromosomes"; Judy Condon, Atlanta, second prize for "Conjugal Transfer of Multiple Drug Resistant Factors from *K. pneumoniae* to *E. coli*"; Brent Barron, Decatur, third prize for "Light Transmission in the Normal, Aging and Cataractous Human Lens."—**Sue McAvoy**

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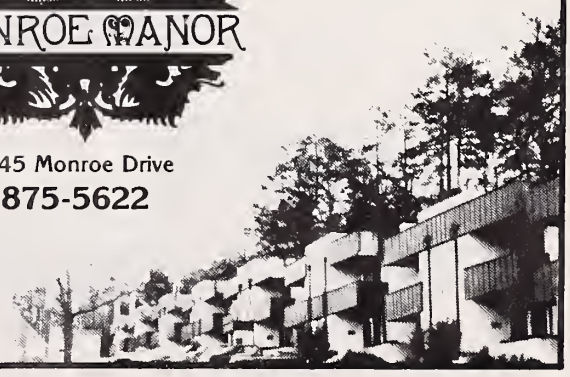
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This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available to members by advanced order for $5 a copy; non-members will be charged $15 per copy.

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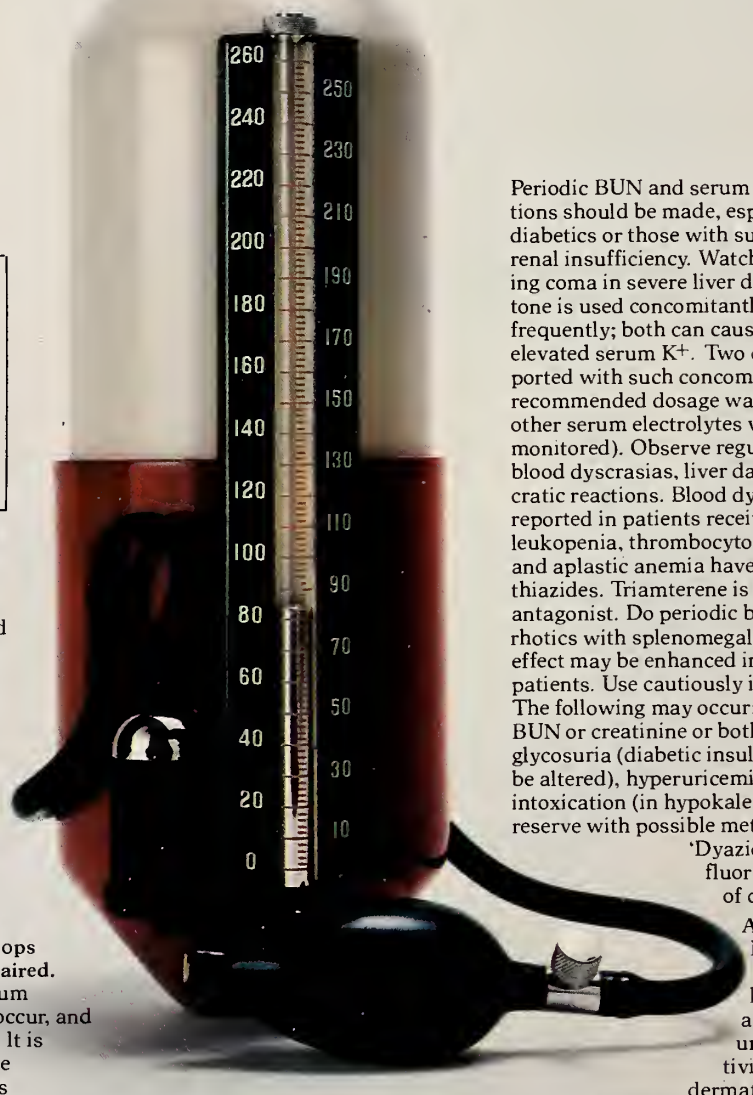
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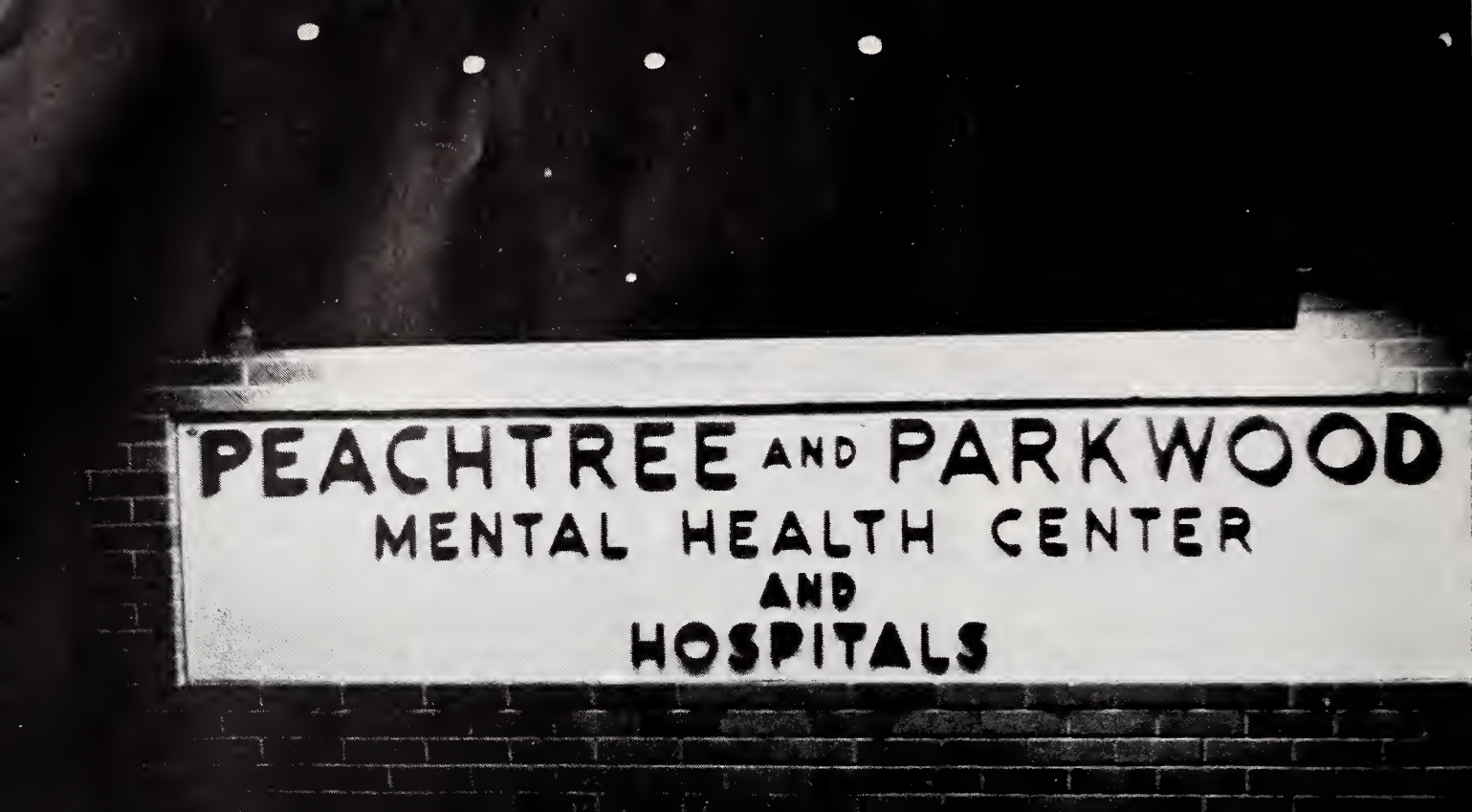


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THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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JOURNAL
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MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

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Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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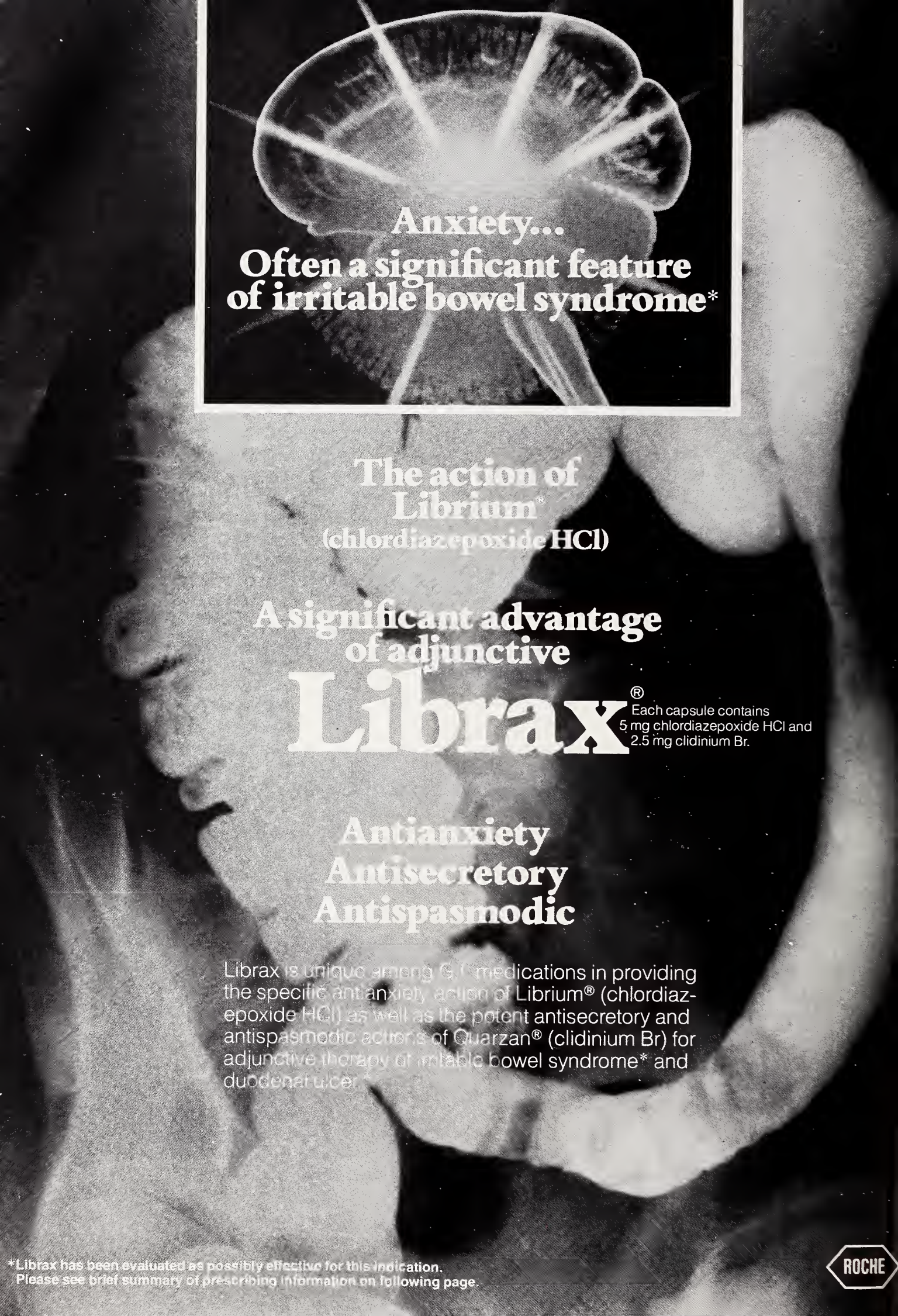
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Please see brief summary of prescribing information on following page.
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Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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THE COVER

The serenity of a lone seagull on the beach at Jekyll Island contrasts the fast-paced and exciting actions which took place during the House of Delegates meeting. Cover photography by Sharon T. Smith; design by Bob Hamill.

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1978-79 ROSTER

One free copy of the 1978 Roster will be mailed to each active member of the Medical Association with the August 1978 issue of the **Journal.**

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available to members by advanced order for $5 a copy; non-members will be charged $15 per copy.

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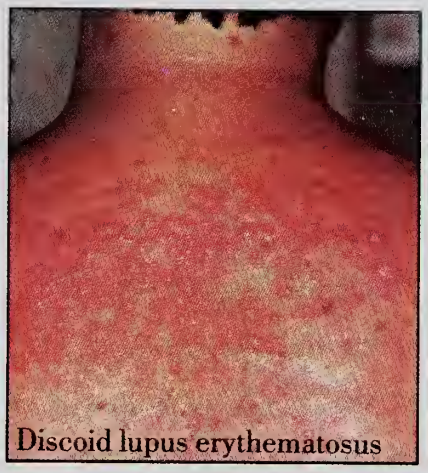
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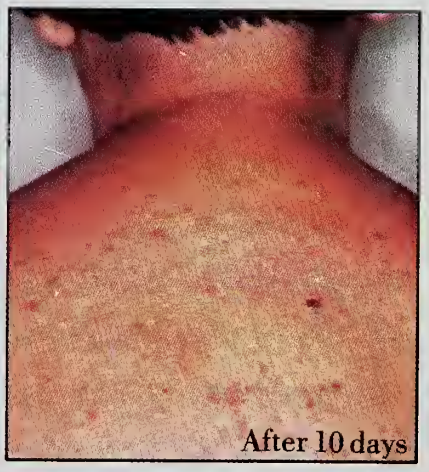


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PRECAUTIONS:
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continue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.

Usage in Pregnancy—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, products of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. Keep the patient under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Discontinue use of the occlusive dressing, elevation of body temperature or

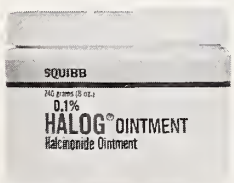
Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If irritation develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning sensation, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

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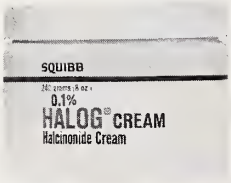


240 g

15 g 60 g



Halog Cream 0.1%
Halcinonide Cream 0.1%

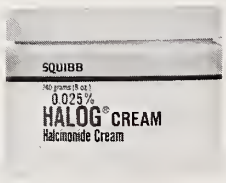


240 g

15 g 60 g



Halog Cream 0.025%
Halcinonide Cream 0.025%



240 g

15 g 60 g



Halog Solution 0.1
Halcinonide Solution



20 ml

60 ml

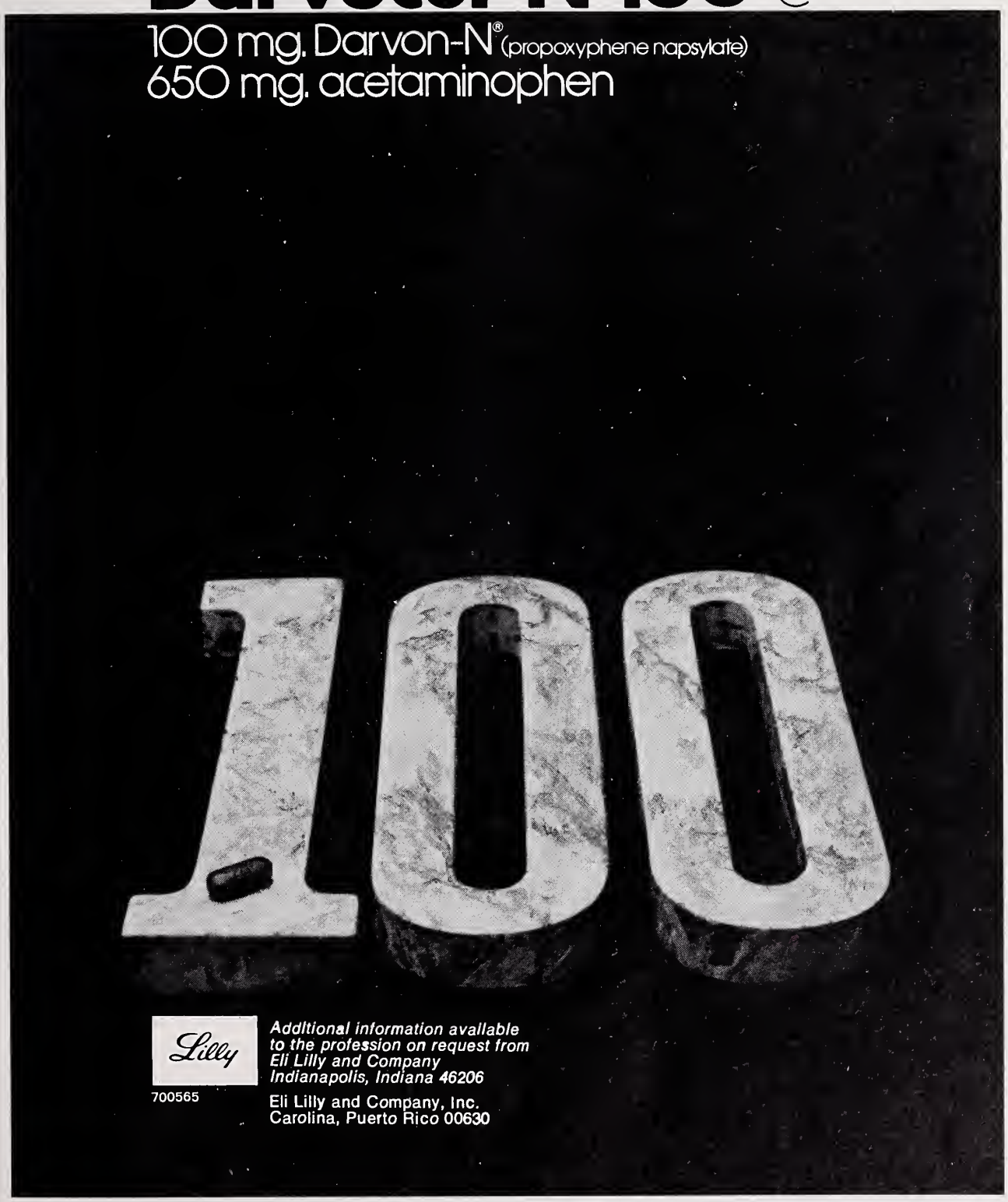


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MEDICAL MEETING CALENDAR

JULY

23-28—*Asheville, NC;* **ANNUAL MEETING, SOUTHERN OBSTETRIC AND GYNECOLOGICAL SEMINAR, INC.;** Contact: W. Otis Duck, M.D., Drawer F, Mars Hill, NC 28754.

25-27—*Washington, DC;* **NATIONAL DISEASE PREVENTION CONFERENCE;** Contact: American Medical Association, 535 North Dearborn St., Chicago, IL 60610.

30-August 2—*Orlando, FL;* **COMPUTERIZED TOMOGRAPHY AND PATIENT MANAGEMENT;** Category 1 Credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

31-August 2—*Jekyll Island;* **PEDIATRICS—COMMON OFFICE PROBLEMS;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404-828-3967.

31-August 4—*Myrtle Beach, SC;* **SIXTH ANNUAL BEACH SYMPOSIUM;** Category 1 Credit; Contact: Bowman Gray School of Medicine, 300 South Hawthorne Rd., Winston-Salem, NC 27103.

31-August 5—*Atlantic Beach, NC;* **CURRENT CONCEPTS IN DIAGNOSTIC RADIOLOGY INCLUDING ULTRASOUND, CT SCANNING AND NUCLEAR MEDICINE;** Category 1 Credit; Contact: Robert McLelland, M.D., Radiology, Box 3808, Duke University Medical Center, Durham, NC 27710.

AUGUST

2-6—*Orlando, FL;* **DIAGNOSTIC IMAGING OF THE HEART;** Category 1 Credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

6-13—*Cashiers, NC;* **SECOND ANNUAL SMOKY MOUNTAIN SEMINAR IN GYNECOLOGY AND OBSTETRICS;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory Universuty School of Medicine, Atlanta 30322.

8—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE AND UROLOGY;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

10-11—*Atlanta;* **UPPER EXTREMITY ADAPTIVE EQUIPMENT;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Emory University School of Medicine, Atlanta 30322.

11-13—*Orlando, FL;* **CLINICAL ELECTROCARDIOGRAPHY AND ARRHYTHMIA MANAGEMENT;** Contact: William E. James, Ph.D., 64 Inverness Dr., Englewood, CO 80110.

13-18—*Lexington, KY;* **NINTH FAMILY MEDICINE REVIEW, SESSION II;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, College of Medicine, Lexington, KY 40506.

15-19—*Atlanta;* **MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM COURSE;** Category 1 Credit; Contact: Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

18-20—*Atlanta;* **CARDIAC SYMPTOMS AND ARRHYTHMIAS—THEIR DIAGNOSIS AND TREATMENT;** Category 1 Credit; Contact: International Medical Education Corporation, 64 Inverness Dr., Englewood, CO 80110.

22-26—*Birmingham, AL;* **MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM COURSE;** Category 1 Credit; Contact: Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

28-29—*Jacksonville, FL;* **LAPAROSCOPY COURSE;** Contact: Robert J. Thompson, M.D., 655 West 8th St., Jacksonville, FL 32209.

SEPTEMBER

6-10—*Hot Springs, VA; 1978* **FALL INSTITUTE, ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION;** Contact: Dr. Stanley Reichman, AHME, 1911 Jefferson Davis Highway, Ste. 905, Arlington, VA 22202. PH: 703-521-1133.

7-9—*Atlanta;* **TUBERCULOSIS CONFERENCE;** Contact: William H. Foege, CDC, U.S. Public Health Service, Building 2, Room 8-47, Atlanta 30333. PH:404-633-3311.

9-10—*Atlanta;* **MEDICO-LEGAL PROBLEMS AND ANESTHESIOLOGY;** Category 1 Credit; Contact: Z. W. Gramling, M.D., Georgia Society of Anesthesiologists, Medical College of Georgia, Augusta 30901.

12—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

14-15—*Gainesville, FL;* **FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM;** Contact: Howard W. Ramsey, M.D., P.O. Box 13494, Gainesville, FL 32604.

18-19—*Jacksonville, FL;* **CLINICAL FAMILY PLANNING FOR PHYSICIANS;** Contact: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville, FL 32209.

21-23—*Williamsburg, VA;* **CARDIOLOGY FOR THE CLINICIAN;** Category 1 Credit; Contact: Tidewater Chapter, American Heart Association, 891 Norfolk Square, Norfolk, VA 23502.

21-23—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Contact: William C. McGarity, M.D., 1365 Clifton Rd., N.E., Atlanta 30322. PH: 404-321-0111.

28-October 1—*Sea Island;* **PRIMARY CARE OF HAND INJURIES;** Category 1 Credit; Contact: Gail M. Gorman, American Society for Surgery of the Hand, 2600 South Parker Rd., #233, Aurora, CO 80014. PH: 303-755-4588.

29-30—*Savannah;* **GEORGIA HEART ASSOCIATION, ANNUAL MEETING AND SCIENTIFIC SESSIONS;** Contact: Georgia Heart Association, 2581 Piedmont Rd., Atlanta 30324. PH: 404-261-2260.

29-30—*Orlando, FL;* **MEETING, AMERICAN SOCIETY OF INTERNAL MEDICINE;** Contact: W. R. Ramsey, 535 Central Tower Building, 703 Market St., San Francisco, CA 903.

30-October 3–Hilton Head, SC; **ANNUAL MEETING, SOUTHERN PSYCHIATRIC ASSOCIATION;** Contact: Annette S. Boutwell, Southern Psychiatric Association, P.O. Box 10387, Raleigh, NC 27605. PH: 919-821-2226.

NOVEMBER

November 11-14—*Atlanta;* **MAG-SOUTHERN MEDICAL ASSOCIATION ANNUAL SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., Atlanta 30309. PH: 404-876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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Highlights of the 1978

THE 1978 ANNUAL SESSION of the Medical Association of Georgia was held at the Jekyll Island Holiday Inn, April 14-16, 1978. Total attendance, including delegates, alternates, members, Auxiliary and guests was 381.

The President's Reception was held on Saturday night, April 15, followed by a banquet. Addresses were delivered by MAG President Milton I. Johnson, M.D., and AMA President John H. Budd, M.D.

At least 350 people attended the annual GaMPAC Breakfast on Sunday.

All resolutions and reports presented to the 1978 House of Delegates and all House actions follow these highlights.

Awards

Jonesboro physician Wells Riley, M.D., received the Family Physician of the Year Award, presented each year to a doctor who "exemplifies the ideals of family practice." Dr. Riley is a past president of the Georgia Academy of Family Physicians.

This year's Civic Endeavor Award was given posthumously to Stone Mountain physician John Rufus Evans, M.D., who died March 6, 1978, at the age of 79. His daughter, Emy (Mrs. H. Duane) Blair, accepted the award in his name. The award is for "outstanding public service and participation in civic activities."

Cost Containment

The Committee on Cost Accountability discussed in its report the background of the Joint Steering Committee for Georgia on Voluntary Cost Containment. It was pointed out that it is desirable for MAG to be involved in cutting cost *voluntarily* instead of having the federal government impose an arbitrary 9% cap on hospital cost increases. The House adopted the recommendation that MAG will support the Steering Committee while *reserving the right to independent action* on any of the Committee's activities.

National Health Insurance

Several resolutions were introduced in the House concerning the subject of national health insurance. The House reaffirmed its opposition to *any form* of NHI, including the one supported by the AMA, and agreed to oppose adamantly by any and all legal means possible any plan to create a comprehensive "universal and mandatory" NHI program.

Physician's Assistants

Much testimony was heard concerning the use and training of physician's assistants. The conclusion of the House was that adequate need for PAs has not been demonstrated. The following recommendation was adopted: "The Medical Association of Georgia recommends to those currently involved in training and certifying physician's assistants in the state of Georgia that, until the need for more physician's assistants can be documented, the training and certification of physician's assistants be terminated and that current training programs be phased out as current training cycles end."

The House voted to define "direct personal supervision of physician extenders" as follows: ". . . as being in the physical presence of the responsible physician or his covering physician designee on a daily basis, and that all decisions regarding diagnosis and treatment must be after direct physical or phone contact with said responsible physician or his covering physician designee. . . ."

Nurse Practitioners

A resolution was presented to certify nurse practitioners through the Georgia Composite State Board of Medical Examiners. Following extended debate. a substitute resolution was adopted which called for the establishment of a new committee to investigate problems associated with the extended role of the nurse and to report its findings to the Board of Directors.

Annual Session

Composite State Board of Medical Examiners

The House adopted a recommendation made by the Ad Hoc Committee on the Composite State Board of Medical Examiners which would double the size of the Board to include two divisions—one of licensure and one of quality assurance. MAG will introduce legislation in the 1979 General Assembly to make this change in the Board. There would be 13 members on each division—ten M.D.s, one osteopath and two lay members.

Insurance Contracts

MAG is opposed to any insurance contract which encourages the signing of a provider agreement by awarding higher fees to participating physicians. It was decided that this practice should be investigated as to its legality and a report from legal counsel on this subject should be made to the Board of Directors.

Peer Review

The House adopted a resolution made by Ogeechee River Medical Society which pointed out that MAG supports only that peer review which is done by private practicing physicians. It was resolved that MAG would recommend a Blue Cross and Blue Shield of Georgia/Columbus that it use the services of the Georgia Medical Care Foundation for its peer review.

Access to Health Care

The 1977 House of Delegates charged the Committee on Access to Health Care to assist local communities in developing general guidelines to use in obtaining physicians as the needs arise. In responding to this charge, the Committee recommended, and the 1978 House adopted, the following recommendation: "When utilizing hospital-employed fee-for-service or salaried emergency room physicians, the hospital should always preserve the patient's right to choose the physician who will treat him and that hospital-employed fee-for-service or salaried emergency room physicians should contain their activities to the emergency room and not be permitted to admit patients in their own names."

Abortions

The Committee on Maternal and Infant Care recommended that if federal funds do not pay for abortions, MAG should recommend that state funds be made available for this purpose. It was pointed out that "at no time did anyone deem to place a monetary value on human life," but the reference committee heard testimony that terminating these pregnancies early would save the state about a half million dollars. The House supported the recommendation that state funds be made available for abortions.

Laetrile

A policy statement was made by MAG's Board of Directors in September 1977. This year's House reworded that statement to read: "The Medical Association of Georgia should continue to inform the public of the dangers of delay in diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective. The Medical Association of Georgia should inform the public that amygdalin has been proven to be unsafe and that the efficacy of amygdalin for the treatment or palliation of malignancies is unproven and that the use of amygdalin in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, and in some cases for the profit of the unscrupulous. It is the position of the Medical Association of Georgia that Laetrile is a substance which has no proven value as a drug."

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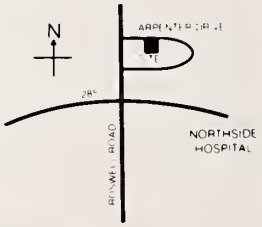
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Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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*Resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

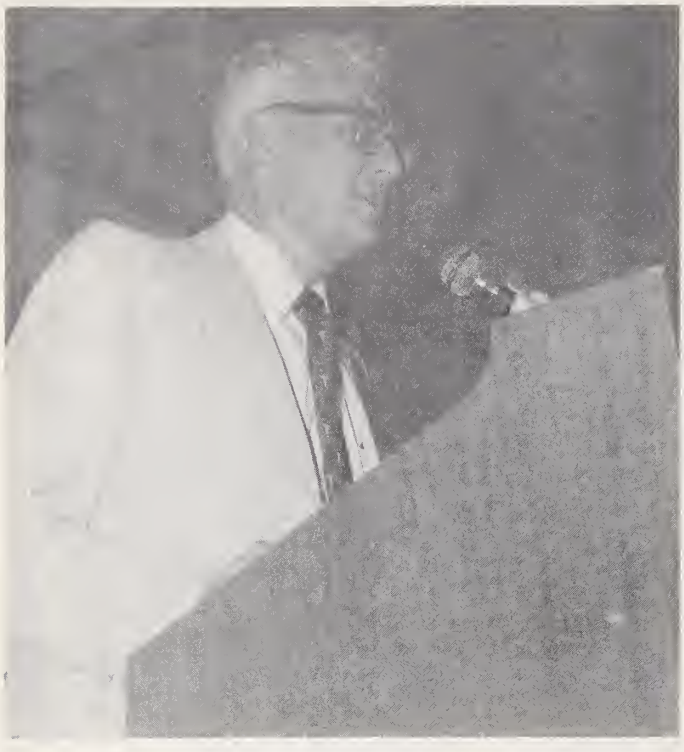
10 times more active against strep than staph.

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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.



Please see brief summary for prescribing information.





President Milton I. Johnson (left) calls to order the first general session. President-Elect Carson B. Burgstiner speaks about his goals for his term as president.

MAG First General Session

1978 Annual Session Business Meeting Friday, April 14, 1978

THE FIRST GENERAL SESSION of the 1978 Annual Business Meeting (House of Delegates) of the Medical Association of Georgia was called to order by the president, Milton I. Johnson, M.D., of Macon at 9:00 a.m., April 14, 1978, in Colony Hall at the Holiday Inn, Jekyll Island, Georgia.

Dr. Johnson introduced the Reverend Edward C. Chapman, from the Christ Church on St. Simon's Island, who gave the invocation.

The opening ceremony consisted of the Pledge of Allegiance said in unison by the assembly and the playing of the National Anthem.

Dr. Johnson then read the names of MAG members who had died since the 1977 Annual Session. They are as follows:

MAG Deceased Members

Elliott A. Ackerman, Decatur
John M. Anderson, Atlanta
Donald E. Beard, Smyrna
William O. Bedingfield, Candler
Jordan Eli Billings, Calhoun
Lester L. Bowles, Martinez
James Gordon Brantley, Wrightsville
L. Ross Brown, Atlanta
O. B. Bush, Atlanta
Joe Bussey Sr., Smyrna
Leroy W. Childs, Atlanta
James A. Elkins, Columbus
J. Rufus Evans, Stone Mountain
Luke G. Garrett Jr., Austell
F. H. Goodwin, Dublin
B. L. Helton, Sandersville
Stewart M. Long, Atlanta
Carl W. Lupo, St. Simons Island
Earl A. Mayo Jr., Richland
J. T. McCall Jr., Rome
Robert E. McClure, Miami, Florida (Atlanta)
Willis T. McCurdy, Stone Mountain
T. W. Middlebrooks, Thomson
Robert E. Perry Jr., Brunswick
Thomas A. Peterson, Savannah

O. C. Pittman, Commerce
John E. Powell Jr., Villa Rica
Paul L. Reith, Warm Springs
Humberto Rodriguez, Valdosta
Paul T. Scoggins, Commerce
Rick S. Shuman, Elberton
Richard H. Smoot, Decatur
Jack Teh, Dalton
W. L. Thomason, Atlanta
John H. Venable, Atlanta
John R. Walker, Alpharetta
William D. Wilson, Savannah
Jimmy G. Woodward, Dahlonega

Following the memorial service, Dr. Johnson introduced Dr. Avery W. Strickland, president of the Glynn County Medical Society, who, in turn, introduced Thomas P. Williams, city commissioner of the City of Brunswick. Dr. Strickland and Mr. Williams both extended official greetings to the assembly from the host county medical society and from the Golden Isles area.

Introduction of Distinguished Guests

Dr. Johnson introduced several distinguished guests: Dr. John Budd, president of the American Medical Association, Mr. David Poythress, commissioner of the Department of Medical Assistance, Mrs. Bruce Barton, president of the Auxiliary to the Southern Medical Association, Mr. Craig A. Barnes, president-elect of the Georgia Hospital Association, Mrs. Melinda McLemore, the Georgia League of Nursing, Mr. Ted Snyder, Prudential Insurance Company of America, Mr. Tom Kinser, vice president of Blue Cross and Blue Shield of Georgia/Atlanta, Mr. Robert Thompson, Mr. Jim Thompson and Mr. Frank Riley, representing Blue Cross and Blue Shield of Georgia/Columbus, Mr. O. W. Wright from the staff of the American Medical Association, Mr. James Willis, Region IV, HEW Medicare, and Mr. C. L. Clifton, executive director of the Composite State Board of Medical Examiners.

At this point, Dr. Johnson introduced Mrs. Russell Andrews of Rome, president of the Auxiliary to the Medical Association of Georgia. Mrs. Andrews gave a brief report on the activities of the Auxiliary during the past year and introduced a special guest, Mrs. Hoyt Gardner, first vice president of the Auxiliary to the American Medical Association. Mrs. Gardner extended greetings from the AMA Auxiliary, and gave a brief report on the activities of that organization. Mrs. Andrews then introduced Mrs. Bruce Martin, who gave a brief report on the Auxiliary to the Southern Medical Association.

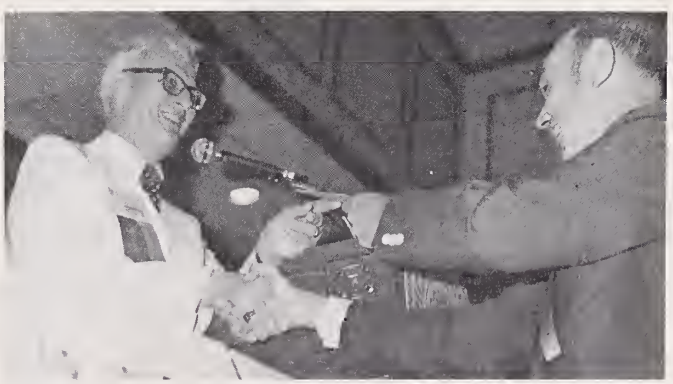
Dr. Johnson called on Carson B. Burgstiner, M.D., president-elect of MAG, who, in turn, spoke briefly on two primary goals of his forthcoming administration: the need for unity and his desire for MAG to become interested in the field of nutrition.

AMA-ERF Awards

Dr. Johnson presented the two Georgia medical schools unrestricted grant monies in the form of an AMA-ERF check, raised by contributions from the physicians and Auxiliary during the previous year. Dr. Johnson presented checks as follows: to the Medical College of Georgia, a check in the amount of $5,137.25, and to the Emory School of Medicine, a check in the amount of $6,026.54.

Following several brief announcements, Dr. Johnson adjourned the First General Session at 9:55 a.m.





Mrs. Bruce Barton, president of the Auxiliary to the Southern Medical Association and one of the distinguished guests, is shown here with Mrs. Betty Andrews, president of the AMAG. Above, Dr. Johnson presents an AMA-ERF grant check to a representative from the Medical College of Georgia.

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Speaker of the House L. C. Buchanan calls the House of Delegates to order.

First Session House of Delegates

Friday, April 14, 1978

THE FIRST SESSION of the House of Delegates was called to order by the speaker, L. C. Buchanan, M.D., at 9:07 a.m., Friday, April 14, 1978, in Colony Hall, Holiday Inn, Jekyll Island, Georgia.

The Speaker extended greetings to all delegates and briefly outlined the responsibilities of the House and the procedure to be followed during the three sessions of the House on April 14, 15 and 16, 1978.

The Speaker called for the report of the delegates in attendance. Hugo S. Moreno, M.D., of East Point, Chairman of the Credentials Committee responded that there were 135 duly-elected delegates registered and present, representing 43 component county medical societies and accordingly announced that a quorum of the House was present.

Attendance

DELEGATES: BALDWIN:Mahmud Majanovic, W. T. Smith, Curtis F. Veal; BARROW: Hugh O. Hodges; BARTOW: Richard A. Griffin III; BIBB: Rodney M. Browne, Cyler D. Garner, Milton I. Johnson, Charles Lanford; Jack F. Menendez, Beverly B. Sanders Jr., Hugh F. Smisson, Alexander H. S. Weaver; OGEECHEE RIVER: Leon E. Curry, Charles R. Richardson; CARROLL-DOUGLAS-HARALSON: Phil C. Astin Jr., Walter S. Gresham; GEORGIA MEDICAL SOCIETY: Carson B. Burgstiner, James P. Evans, Edgar J. Filson, O. Emerson Ham Jr., James Moultrie Lee, James R. Logan, D. A. Nash, Joe L. Nettles, Eloise B. Sherman, Roland S. Summers; ELBERT: John B. O'Neal III; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: Lucien A. Flint; CRAWFORD W. LONG: James H. Beall, E. V. Herrin, A. D. Muse Jr., Larkus H. Pesnell; CLAYTON-FAYETTE: Ernest A. Dunbar Jr., Leslie M. Feinsmith, Clyde C. Harrison Jr.; COBB: Richard W. Cohen, Virgil L. Curry, Philip Z. Israel, Bruce A. Kyburz, Stephen C. May Jr., Frank W. McKinnon, J. Gary Palmer Jr., Harry Porter Jr., Charles J. Rey Jr., Dan B. Stephens, Charles R. Underwood; COFFEE: William R. Wills Jr.; COLQUITT: John P. Tucker; DECATUR-SEMINOLE: Frank L. Gibson; DEKALB: Stanley P. Aldridge, H. Duane Blair, L. C. Buchanan, William R. Hardcastle, John P. Heard, Richard C. Mattison, Charles W. McDowell Jr., LaMar S. McGinnis Jr., Clyde B. Rountree, Ralph A. Tillman, Roy W. Vandiver, Theodore C. Whitson; DOUGHERTY: J. Dan Bateman, David M. Boyette, Carl V. Hancock Jr., Charles D. Hollis Jr.; CAMDEN-CHARLTON: Joseph M. Jackson; EMANUEL: R. J. Moye; FLINT: Joseph T. Christmas; FLOYD-POLK-CHATTOOGA: John F. Atha, Sidney A. Bell, Toby S. Morgan, James H. Smith; FRANKLIN-HART: Robert F. Sullivan;

MEDICAL ASSOCIATION OF ATLANTA: Patrick L. Anders, Thomas J. Anderson Jr., John S. Atwater, Hugh V. Bell Jr., Linton H. Bishop Jr., Allan C. Bleich, Spencer S. Brewer Jr., E. Napier Burson Jr., William C. Collins, David E. Dalrymple, F. William Dowda,

Richard E. DuBois, Julius Ehik, E. C. Evans, Louis H. Felder, Joseph L. Girardeau, Charles E. Harrison Jr., J. Rhodes Haverty, William E. Huger Jr., Fleming L. Jolley, W. Lanier Jones, W. Dan Jordan, James A. Kaufmann, Luella Klein, Bob G. Lanier, William M. Lester, William D. Logan Jr., Joe B. Massey, John T. Mauldin, John R. McCain, John M. McCoy, W. W. Moore, Hugo S. Moreno, Lea Richmond, Harrison L. Rogers Jr., J. K. Schellack, William B. Spearman, Hugh S. Thompson Jr., Thomas L. Tidmore Jr., Charles E. Todd Jr., L. Newton Turk III, William C. Waters III, Robert E. Wells, William H. Whaley, Frank L. Wilson Jr., J. S. Wilson, John T. Yauger; GLYNN: Michael A. Glucksman, Donald H. Manning, Edwin A. Mayo; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: John Knox Burns III, Bradwell R. McAlister, John H. Reed Jr.; PEACH BELT: V. W. McEver Jr., H. E. Weems Jr.; JACKSON-BANKS: Joe L. Griffeth; LAURENS: Robert W. Oliver Jr., Quentin Price; McDUFFIE: Thomas E. Averitt; MITCHELL: William C. Arwood Jr.; MUSCOGEE: Marvyn D. Cohen, J. H. Deaton, Kenneth L. Goldman, Bob R. Maughon, Edmund M. Molnar, Bruce C. Newsom, John S. Newton, Jack A. Raines, James H. Sullivan; NEWTON-ROCKDALE: Terrell B. Tanner; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Joseph P. Bailey, William E. Barfield, Claud A. Boyd Jr., Ronald F. Galloway, Glen E. Garrison, Jimpsey B. Johnson, Julius T. Johnson, James K. McDonald, Michael J. Murphy, Stuart H. Prather, Henry D. Scoggins, Luther M. Thomas Jr., Charles H. Wray; SOUTH GEORGIA: F. G. Eldridge, Joe C. Stubbs; SOUTHEAST GEORGIA: George W. Merritt; SPALDING: Henry A. Foster, James M. Skinner; STEPHENS-RABUN: Irving D. Hellenga, C. Peter Lampros; ST. JOHNS PARISH: Frank T. Robbins; THOMAS AREA: Frank R. Miller, Gerald B. Muller, William A. Trevejo; TIFT: Stewart D. Gilbert, Robley D. Smith; TROUP: Joseph M. Almand Jr., H. Hilt Hammett Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Ted D. Cash; WARE: Spurgeon William Clark Jr., Floyd E. Davis; WASHINGTON: William Rawlings; WAYNE: Ollie O. McGahee Jr.; WHITFIELD-MURRAY: William M. Blackman, Robert W. Simmons, David A. Wells; WORTH: H. G. Davis Jr.

ALTERNATES: CLAYTON-FAYETTE: Wells Riley; COBB: Remery Y. Clark Jr.; DEKALB: Harold H. Carspecken, Andy P. Morley Jr., James A. Walker; DOUGHERTY: George M. Chastain, Chappell A. Collins Jr., L. T. Crimmins; GLYNN: Avery W. Strickland; MUSCOGEE: James M. Eaton Jr., William H. Hayes, William C. T. Jernigan, Donald M. Kurtz, William A. Wolff; RICHMOND: Betty B. Wray; SOUTHEAST GEORGIA: James E. Barfield; TELFAIR: F. A. Smith Jr.; UPSON: Norman P. Gardner.

GUESTS: Mr. Craig A. Barnes, John Budd, M.D., Mrs. Budd, Mr. Cecil L. Clifton, Mr. Tom Kinser, Mrs. Bruce Martin, Mrs. Melinda McLamore, Mr. David Poythress, Mr. Frank Riley, Mr. Ted Snyder, Mr. Jim Thompson, Mr. Robert Thompson, Mr. James Willis, Mr. Bud Wright.

Speaker Buchanan thanked the chairman of the Credentials Committee, presented the vice speaker, Dr. Jack Menendez, to the assembly, and explained in some detail the procedures to be followed for the consideration of business that would come before the House of Delegates for the remainder of the session. The Speaker appointed Dr. Ronald Galloway to act as parliamentarian during the 1978 meetings of the House.

Appointment of Committees

The Speaker announced the appointment of the House of Delegates Credentials Committee, Tellers Committee, and Reference Committees as follows:

CREDENTIALS COMMITTEE: Hugo S. Moreno, East Point, chairman; Beverly B. Sanders Jr., Macon; A. D. Muse Jr., Athens.

TELLERS COMMITTEE: T.A. Sappington, Thomaston, chairman; Hugh O. Hodges, Winder; Claud A. Boyd Jr., Augusta; William M. Blackman, Dalton.

REFERENCE COMMITTEE A: S. W. Clark Jr., Waycross, chairman; LaMar S. McGinnis Jr., Decatur, vice chairman; Joseph T. Christmas, Vienna; D. Hubert Manning, Brunswick; William D. Logan Jr., Atlanta; Charles J. Rey Jr., Austell.

REFERENCE COMMITTEE B: Alexander H. S. Weaver, Macon, co-chairman; Frank W. McKinnon, Marietta, co-chairman; Joe L. Nettles, Savannah; Charles W. McDowell Jr., Decatur; William C. Collins, Atlanta; Ronald F. Galloway, Augusta.

REFERENCE COMMITTEE C: John P. Heard, Decatur, chairman; Fleming L. Jolley, Atlanta, vice chairman; Thomas M. Lumsden, Clarkesville; Edmund M. Molnar, Columbus; R. D. Walter, Calhoun; Jimpsey B. Johnson, Augusta.

REFERENCE COMMITTEE D: Charles B. Hollis Jr., Albany, chairman; Marvyn D. Cohen, Columbus, vice chairman; Ralph A. Tillman, Decatur; William B. Spearman, Atlanta; John G. Bates, Cuthbert; Philip Z. Israel, Smyrna.

COMMITTEE ON CONSTITUTION AND BYLAWS: Jack A. Raines, Columbus, chairman; Richard C. Mattison, Decatur, vice chairman; Donald C. Abele, Augusta; Richard A. Griffin III, Cartersville; Thomas J. Anderson Jr., Atlanta; Charles M. Richardson, Statesboro.

REFERENCE COMMITTEE F: William E. Huger Jr., Atlanta, chairman; Rupert H. Bramblett, Cumming; L. Austin Flint, Canton; Cyler D. Garner, Gordon; William R. Hardcastle, Tucker; Stuart H. Prather Jr., Augusta.

The Speaker announced that the proceedings of the 1977 Annual Session had been published in the June 1977 issue of the *Journal of the Medical Association of Georgia* and called for any corrections that should be made.

On motion duly made and seconded, it was voted that the proceedings of the 1977 meeting, as pub-

lished in the June 1977 issue of *JMAG* be approved as published.

Nominations

Speaker Buchanan called to the House to proceed with nominations of officers, AMA delegates and alternates, directors and alternate directors. He reminded the House that the election would be held on Sunday morning with the voting hours between 7 a.m. and 9 a.m., and that ballots would be provided by the Credentials Committee.

The Speaker asked for nominations for the office of MAG president-elect and the following nomination was made:

PRESIDENT-ELECT: Earnest C. Atkins, Decatur, was nominated by H. Duane Blair, Decatur. Dr. Atkins' candidacy was seconded by F. G. Eldridge, M. A. Glucksman, C. Emory Bohler, E. M. Molnar, James A. Kaufmann, Philip Z. Israel, H. Hilt Hammett Jr., Ronald F. Galloway, Charles E. Harrison Jr., Jack Menendez and F. W. Dowda. There being no further nominations for the office of president-elect, the nominations were closed.

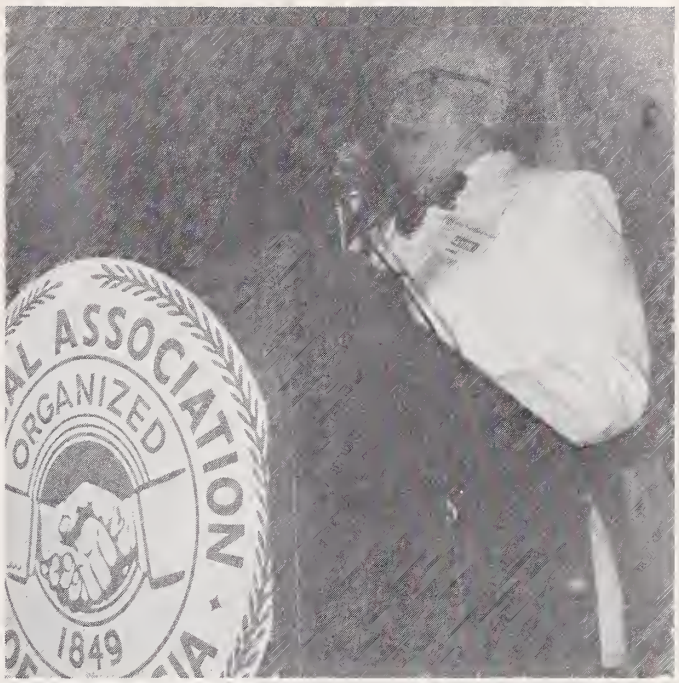
SECOND VICE PRESIDENT: Richard A. Griffin III, Cartersville, was nominated for the office of second vice president by L. C. Durrence Jr., Blackshear. Dr. Griffin's candidacy was seconded by Roy W. Vandiver, E. M. Molnar, Ronald F. Galloway and Toby S. Morgan. There being no further nominations for the office of second vice president, the nominations were closed.

SECRETARY: William D. Logan, Atlanta, was nominated for the office of secretary by Charles E. Harrison Jr. Dr. Logan's candidacy was seconded by Thomas L. Tidmore Jr., Edwin C. Evans, LaMar S. McGinnis Jr., Charles R. Underwood, Charles D. Hollis Jr., Ronald F. Galloway, Bob R. Maughon, Thomas J. Anderson Jr., A. D. Muse, Jack Menendez and Fleming L. Jolley.

L. Austin Flint, Canton, was nominated for the office of secretary by Charles Andrews. Dr. Flint's candidacy was seconded by C. Emory Bohler, Stewart D. Gilbert, Rupert H. Bramblett, H. Duane Blair and Harvey M. Newman. There being no further nominations for the office of secretary, the nominations were closed.

TREASURER: James H. Sullivan, Columbus, was nominated for the office of treasurer by Bruce C. Newsom. Dr. Sullivan's candidacy was seconded by H. Hilt Hammett Jr., F. G. Eldridge, David A. Wells, Beverly B. Sanders Jr., William C. Collins, Carson B. Burgstiner, J. Gary Palmer and Ronald F. Galloway. There being no further nominations for the office of treasurer, the nominations were closed.

AMA DELEGATES: Speaker Buchanan called for nominations for delegates to the American Medical Association and for alternate delegates, observing that the term of all new delegates and alternates would begin on January 1, 1979.



Earnest Atkins accepts the nomination for the position of president-elect after receiving a standing ovation from the House.

For the AMA Delegate seat currently held by Harrison L. Rogers Jr., Atlanta, Dr. Rogers was nominated by F. William Dowda. Dr. Rogers' candidacy was seconded by John Heard.

Dr. Heard then moved that incumbent AMA Delegates Harrison L. Rogers Jr. and J. Dan Bateman, and Alternate Delegates H. Hilt Hammett Jr. and William W. Moore be renominated and presented as a slate. Each was duly seconded. There being no further nominations for the position of AMA delegate or alternate delegate, the nominations were closed.

Directors and Alternate Directors

Dr. Buchanan announced the results of the election for directors and alternate directors as conducted by the component medical societies:

NINTH DISTRICT director: Rupert H. Bramblett, Cumming (1981). Alternate director: L. Austin Flint, Canton (1981).

TENTH DISTRICT director: M. A. Hubert, Athens (1981). Alternate director: William M. Headley, Milledgeville (1981).

BIBB COUNTY MEDICAL SOCIETY director: Beverly B. Sanders Jr., Macon (1981). Alternate director: Rodney M. Browne, Macon (1981).

COBB COUNTY MEDICAL SOCIETY director: Charles R. Underwood, Marietta (1981). Alternate director: Frank W. McKinnon, Marietta (1981).

DEKALB MEDICAL SOCIETY director: John

P. Heard, Decatur (1981). Alternate director: Roy W. Vandiver, Decatur (1981).

FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY director: John 1. Dickinson, Rome (1981). Alternate director: Lee H. Battle Jr., Rome (1981).

MEDICAL ASSOCIATION OF ATLANTA director: T. J. Anderson, Jr., Atlanta (1981). Alternate director: William D. Logan Jr., Atlanta (1981).

RICMOND COUNTY MEDICAL SOCIETY director: Ronald F. Galloway, Augusta (1981). Alternate director: Henry D. Scoggins, Augusta (1981).

Screening Late Resolutions

Speaker Buchanan announced a new procedure for the screening of late resolutions to determine the urgency of such resolutions and thereby determined if they must be taken up at this meeting. The Chair's decision to subject late resolutions for screening by the Annual Session Committee was appealed from the floor. On vote taken, the appeal was defeated and the position of the Chair was sustained.

Annual Reports

Speaker Buchanan called for the Annual Reports of MAG officers, directors, committees, and other reports to be introduced at this session which are listed below with the reference committee to which these reports were referred appropriately indicated. (Editorial note: Each complete report, the action of the reference committee and the subsequent action taken by the House of Delegates on all reports referred to reference committees will be found under the proceedings of the second session and the third session of the House of Delegates. See pages 507-578).

REPORTS OF OFFICERS

President—F
Immediate Past President—Not Referred
First Vice President—Not Referred
Second Vice President—Not Referred
Secretary—B
Treasurer—Not Referred
Chairman of the Board—Not Referred
Speaker of the House—A
AMA Delegation—A

REPORTS OF DIRECTORS

AMA Delegation—A
1st District—Not Referred
2nd District—Not Referred
3rd District—Not Referred
6th District—Not Referred
7th District—Not Referred
8th District—Not Referred
9th District—Not Referred
10th District—Not Referred
Bibb County Medical Society—Not Referred
Cobb County Medical Society—Not Referred
DeKalb County Medical Society—Not Referred
Floyd-Polk-Chattooga County Medical Society—Not Referred
Georgia Medical Society—Not Referred
Medical Association of Atlanta—Not Referred
Muscogee County Medical Society—Not Referred
Richmond County Medical Society—Not Referred

REPORTS OF COMMITTEES

Access to Health Care—B
Allied Health—Not Referred
Auxiliary—Not Referred
Board of Directors—Budget—F
Cancer (Recommendations 1 and 4)—C
Cancer (Recommendations 2 and 3)—D
Communications—D
Constitution & Bylaws—Constitution & Bylaws
Cost Accountability—F
Countersuit Review—Not Referred
Crawford W. Long Memorial—Not Referred
Disabled Doctors—Not Referred
Education—D
Health Planning—A
Internal Review—Internal Review
Joint Hospital Survey Project—A
Laboratory Quality—Not Referred
Legislation—C
Liaison to Board of Human Resources—A
Liaison to the Georgia State Medical Association—Not Referred
Maternal and Infant Health—C
Medical Practice—Not Referred
Medicine and Human Values—C
Membership—A
Mental Health—Not Referred
Nursing—B
Occupational Health—Not Referred
Peer Review—D
Physician Assistants—B
Physician-Lawyer Liaison—Not Referred
Prison Health—A
Public Health—Not Referred
School Child Health—Not Referred
Scientific Assembly—D
Talmadge Hospital Liaison—D
Third Party Relations—C
Third Party Relations Supplemental—C
Transfusion and Transplantation—Not Referred
Ad Hoc on Public Relations—Not Referred
Ad Hoc on State Board of Medical Examiners—A
Ad Hoc to Study Building and Land—Not Referred

Georgia Medical Care Foundation—Not Referred
Auxiliary to MAG—Not Referred
Journal of the Medical Association of Georgia–Not Referred

The Speaker called attention to the reports which are shown as having no recommendations, and thus have not been referred to any reference committee. He called upon the delegates to request referral of any report they desire to see go to a reference committee. The Speaker then announced that all reports not referred to a reference committee would be filed for information. They are as follows:

IMMEDIATE PAST PRESIDENT

Fleming L. Jolley, M.D.

The Medical Association of Georgia is a good organization and it can be better. Perhaps it is a compromise organization but then with the wide variance of membership, how else could it be?

At times one must question where within lies its strength. It seems the stability of some relates to the annual leadership changes.

Thanks again to each of you for the kind remarks and generous help.

FIRST VICE PRESIDENT

Milton I. Johnson Jr., M.D.

Your first vice president has tried to be faithful in attendance and participation in the affairs of our Association. It staggers the imagination to view the kaleidoscope of events that come before the Executive Committee and Board of Directors.

You may recall that last year I recommended that consideration be given to employing an outside firm to review our organization with the idea of improving efficiency. The House of Delegates elected to appoint a committee to be formed to perform an internal review, to be followed by an external review. I look forward to reading their reports.

An unprecedented event this year has been the sudden death of our president, Dr. Robert E. Perry Jr. of Brunswick, giving me the awesome responsibility of trying to fill his shoes as president. This I have tried to do to the best of my ability.

I appreciate the honor of serving as your first vice president. It has provided me with an opportunity for learning and experience that I shall never forget.

SECOND VICE PRESIDENT

L. Newton Turk III, M.D.

Your second vice president has, together with the other members of the Board of Directors and Executive Committee, considered and acted upon a large number of matters both ponderous and pedestrian. In my judgement, your officers and directors, to a man, have served you well. They are an outstanding group of leaders and if has been a pleasure to work with them on your behalf.

I believe there are ways to further streamline and increase the efficiency of the deliberative bodies of the Association and if it should come to pass that I am empowered to serve the organization beyond the vice presidential level, I would try to effect these goals.

I would call your attention to only one specific matter scheduled to come before the House of Delegates: the proposal to be drafted by Drs. Glucksman and Raines calling for formation of physicians organizations paralleling the HSA boards and councils to serve both as watchdogs over and advisory groups to the HSAs and to keep MAG members informed of HSA activities. This, I feel, has real potential merit, and I would strongly favor its adoption and implementation.

CHAIRMAN OF THE BOARD OF DIRECTORS

Joe C. Stubbs, M.D.

Having assumed the chairmanship of the board of directors of the Medical Association of Georgia in April of 1977, I have presided at meetings every three months since that time with a great deal of work having been accomplished by the members of the Board with the able assistance of the Headquarters staff. The Board is composed of 36 directors and alternate directors representing each of the districts over the state, plus the officers and past presidents. Attendance has been excellent with not only Board members attending but frequent guests so that overall size of the meetings ranges between 70 and 80 present at each meeting.

During the past year a number of major accomplishments have been achieved by the Board of Directors. One of our real victories was the successful campaign to elect Harrison L. Rogers, M.D., Atlanta, as Vice Speaker of the AMA. "Jack" Rogers has given us able representation on the national level.

Other accomplishments are:

Laetrile: On this controversial and much publicized substance, the Board adopted a resolution recommended by the Committee on Cancer to continue to inform the public of the danger in delay of diagnosis and treatment of malignancies, and that laetrile is a substance which has no proven value as a drug.

Professional Liability: Endorsed the concept of creating a continuing education course of high quality on professional liability risk management. A Committee on Risk Management was appointed to explore this concept.

Medical Laws Booklet for Georgia Physicians: Approved printing a booklet on Georgia laws related to medical practice to be distributed to the membership with an adequate supply to furnish new incoming members.

GaMPAC: Increased the GaMPAC Board to thirty (30) members comprised of two physician members and one Auxiliary member from each congressional district to stimulate more interest at the district level.

History of MAG/Georgia Medical Society: Approved funds, to be supplemented by funds from the Savannah

society (Georgia's oldest medical society) to compile and print a souvenir history of MAG and Georgia Medical Society for distribution at the 1979 Annual Session to be held in Savannah.

PSRO: Approved the Georgia Medical Care Foundation as the proper entity to apply for a PSRO planning contract (as directed by the 1977 House of Delegates to decide whether MAG, PSROG or GMCF should apply). The Foundation was approved as the PSRO for the State of Georgia and has received a planning contract for $199,128 for 1978.

Headquarters Building: As a result of the good financial condition of the Association, an accelerated mortgage payment of $110,000 was made on the Headquarters building which was possible without penalty and created a savings of $8,255 for MAG since interest on the loan is in excess of interest earned on funds invested in Certificates of Deposit.

Patient Opinion Survey on National Health Insurance: Approved the concept of conducting this survey on a voluntary basis by Georgia physicians via a questionnaire to patients. Final action will be determined at the April 1978 Board meeting.

MAG Information System (Computer): Despite the severe impact on MAG's Information Systems resulting from loss of the CHAMPUS contract, the Board of Directors approved continuing funding during the remainder of the current fiscal year to maintain a staff and authorized negotiating a contract with Georgia Medical Care Foundation for its computer needs.

Atlanta Blue Cross/Blue Shield Utilization Review Plan: Adopted a position on utilization review as follows: That MAG support the concept that every hospital medical staff should have a viable, active and effective utilization review mechanism, recognizing, of course, that specific needs will vary from place to place, and that in some instances, combined or joint efforts by smaller facilities may be necessary in order to provide utilization review of an acceptable quality. MAG agrees strongly that true utilization review by physicians should be done only to determine the appropriateness and quality of care rendered. It should never be performed as fiscal review. MAG does not believe that physicians performing medical services should be required to perform utilization review simply to aid a facility, insurer or other third party to reduce their operating costs.

Medical Examiner's System: Appointed an ad hoc committee to study development of legislation for an improved medical examiner's system for Georgia.

Certificate of Need: Approved the recommendation of an Ad Hoc Committee on Certificate of Need which advocated that MAG not oppose efforts to amend the Georgia Constitution that would be required as a precondition to the enactment of Certificate of Need legislation provided such legislation does not surpass the minimum requirements imposed by federal law.

In addition to the above, several minor innovations have been developed to improve the workings of the meetings themselves and consideration is being given to the possibility of trying a system of time allotments for each subject to be discussed with the hope of making the meetings move along more swiftly.

It has been a pleasure to serve as the Chairman of this very active and integral part of our great state organization. I would like to extend my appreciation to all of the staff and most especially to Lola Inman Brown for her long and hard hours devoted to our Board meetings.

TREASURER

James H. Sullivan, M.D.

It has been an honor, a privilege, and a pleasure to serve the Medical Association of Georgia as your treasurer for this past year, 1977-78. Since our last dues raise in 1976 the budget and the dues structure of MAG has become stabilized. Hopefully this will prevent utilizing the time of the House of Delegates at each year's session.

Our financial standing is excellent and as promised the utilization of funds has been closely scrutinized with emphasis on austerity, planning, and fiscal responsibility. We are commanding at the present time the highest interest available for our savings.

We have strived even harder and at the present time are almost now totally devoid of any federal finance income and truly the Medical Association of Georgia is representative of private enterprise. We have strived to hold down large expenditure of funds at Executive Committee and Board of Directors meetings by having any financial requests directed through the office of Treasurer prior to any of the meetings.

We are faced in the coming years with the loss of CHAMPUS and the Medical Association of Georgia's direction of this program.

We have increased the sinking fund for land and ground acquisition in anticipation of a future move for MAG headquarters.

We have financed and have had a very successful MAGNET Conference which in future years should really increase the opportunity for socio-economic education for new members and office staff personnel.

We have financed and have had a successful Scientific Session of MAG involving the specialty societies and holding the Scientific Session separate from the House of Delegates meeting as was requested by the House of Delegates.

GaMPAC is a very important viable part of our organization and each of us in MAG owes a tremendous debt to these hard workers for their political activism.

The MAG benevolent fund is financially stable and self-sustaining. Our individual association committees have done an excellent job. Their expenditure of funds has been necessary and the application of these funds extremely efficient.

There has been a turn over in MAG staff headquarters personnel with a remodeling of the headquarters in the process.

With the monthly rise in inflation, with the increase in federal taxes and social security, MAG remains ahead of any financial difficulty. This attitude should prevail for many years to come.

I have enjoyed very much working for the Medical Association of Georgia in the position as treasurer and I would like to thank personally, Mr. L. B. Storey Jr., who continually demonstrates an extreme dedication to the Medical Association of Georgia. Without his knowledge of financial affairs, accounting and business attitude the office of treasurer and the Medical Association of Georgia itself would not be such a viable organization.

REPORTS OF DIRECTORS

FIRST DISTRICT

Leon E. Curry, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Ogeechee River				
J. Dorsey Smith				
Metter	30	27	33	27
Burke				
Walter R. Voyles				
Waynesboro	4	4	4	3
Emanuel				
H. Wilder Smith				
Swainsboro	5	5	5	4
Laurens				
Grady E. Longino				
Dublin	30	22	35	22
Screven				
Kathrine R. Hawkins				
Sylvania	5	5	6	6
Southeast Georgia				
A. J. Morris				
Vidalia	10	8	11	5
St. John's Parish				
Ruben Silan				
Hinesville	8	1	7	0
	92	72	101	67

SECOND DISTRICT

J. Dan Bateman, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Colquitt				
Leonard P. LaConte				
Moultrie	18	14	20	16
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	11	9	14	9
Dougherty				
Carl V. Hancock Jr.				
Albany	86	68	92	72
Mitchell				
A. A. McNeill Jr.				
Camilla	3	3	5	3
Southwest Georgia				
Virendra M. Saxena				
Ft. Gaines	9	2	11	2
Thomas Area				
Thomas E. Arnett				
Thomasville	49	45	51	35
Tift				
Stewart Gilbert				
Tifton	24	16	26	15
Worth				
R. T. Morgan				
Sylvester	5	2	5	2
	205	159	224	154

THIRD DISTRICT

John H. Robinson, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Flint				
Charles C. Greer, III				
Cordele	15	7	18	11
Peach Belt				
Ken Raynor				
Warner Robins	42	36	45	40
Randolph-Stewart-Terrell				
Thomas Allen				
Dawson	7	4	5	5
Sumter				
William R. Anderson				
Americus	21	18	20	13
	85	65	88	69

SIXTH DISTRICT

James M. Skinner, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Clayton-Fayette				
Jacqueline Werner				
Riverdale	41	29	54	28
Coweta				
George T. Jarrard				
Newnan	24	21	26	20
Meriwether-Harris-Talbot				
William G. Chambless				
Hamilton	12	11	8	6
Spalding				
Robert J. Caswell				
Griffin	41	35	36	31
Troup				
Owen K. Tidwell				
LaGrange	43	33	39	36
Upson				
R. S. Shacklett				
Thomaston	22	19	22	16
	183	148	185	137

SEVENTH DISTRICT

Richard A. Griffin III, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Bartow				
William B. Dillard Jr.				
Cartersville	10	8	8	7
Carroll-Douglas-Haralson				
John E. Godard				
Carrollton	36	29	45	30
Gordon				
Bill Purcell				
Calhoun	10	9	9	7

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Walker-Catoosa-Dade Thomas E. Hayes Chattanooga, Tenn.	29	16	40	26
Whitfield-Murray Rodger H. Eidson Dalton	59	48	62	44
	144	110	164	114

EIGHTH DISTRICT

Joe C. Stubbs, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Altamaha J. J. Hernandez Baxley	5	4	3	1
Ben Hill-Irwin Ralph Roberts Fitzgerald	5	4	5	4
Coffee Jack G. Williams Douglas	18	12	17	11
Camden-Charlton Eduardo Oliveira St. Mary's	8	5	6	3
Glynn Tom V. Willis Jr. Brunswick	58	49	64	44
Ocmulgee George S. Walker III Eastman	15	12	16	12
South Georgia Edwin Hiatt Valdosta	67	39	71	34
Telfair D. B. McRae McRae	4	4	6	5
Ware L. J. Duane Jr. Waycross	48	39	48	34
Wayne Ollie O. McGahee Jr. Jesup	8	5	9	8
	236	173	245	156

NINTH DISTRICT

Harvey M. Newman, M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Barrow W. Quentin Randolph Winder	7	2	8	3
Blue Ridge	(Disbanded)		(Disbanded)	
Chattahoochee Rupert H. Bramblett Cumming	26	24	28	22
Cherokee-Pickens Robert T. Anderson Canton	18	7	19	8
Elbert Rick Shuman Elberton	7	4	8	7
Franklin-Hart Robert F. Sullivan Carnesville	8	8	8	8
Habersham R. D. Doshi Demorest	12	7	13	7
Hall James M. Alday Gainesville	81	65	87	64
Jackson-Banks Sam A. Vickery Commerce	7	7	7	4
Stephens-Rabun Henry M. Hobby Toccoa	24	13	26	11
	190	137	204	134

TENTH DISTRICT

Edwin W. Allen Jr., M.D.

Counties and Secretaries	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Baldwin Virgilio Q. Valdecanas Milledgeville	50	22	51	19
Crawford W. Long E. Van Herrin Athens	81	63	80	61
Jefferson A. F. Dumais Louisville	7	5	5	4
McDuffie Morgan N. Whaley Thomson	7	—	5	6
Newton-Rockdale Robert L. Faulkner Covington	12	7	13	8
Oconee Valley J. Lee Parker Greensboro	8	8	10	8
Walton J. Howard Barton Social Circle	6	—	8	7
Washington William Rawlings Jr. Sandersville	—	—	7	2
Wilkes C. E. Pollock Washington	5	5	5	5
	181	112	184	120

BIBB COUNTY MEDICAL SOCIETY

Beverly B. Sanders Jr., M.D.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Bibb Herbert S. Greenwald Macon	206	166	207	152

COBB COUNTY MEDICAL SOCIETY

Charles R. Underwood, M.D.

The past year has seen continued growth and activity of the Cobb County Medical Society in many areas. Taking cognizance of the increased public and professional awareness of the quality and cost of medical care, the Society has actively engaged itself in several areas of pursuit relative to these problems. We are represented on the North Central Georgia Health Systems Agency by Norman Bowles and on the Atlanta Regional Commission by Richard Cohen—both are active and interested physicians with keen realization of the necessity for medical input into the public and governmental organizational aspects of the practice of medicine.

Cost containment committees have been encouraged at each hospital throughout the county and ongoing efforts to arouse physician awareness to this problem have been instituted. One of our hospitals, Kennestone in Marietta, was the 1977 winner of the Proven Application for Cost Effectiveness Reward Contest, co-sponsored by the Georgia Hospital Association and the Blue Cross and Blue Shield Plans of Columbus and Atlanta. Following spirited and constructive debate and in-depth investigation, all of our hospitals are planning to participate in the cost containment project of Blue Cross and Blue Shield of Georgia/Atlanta through the hospitalization utilization review program.

We continue to be concerned about physicians in our area who are not presently affiliated with the County Medical Society and are actively attempting to bring these individuals into a membership status.

Numerous community projects have been aggressively pursued, including the giving of annual physical examinations free of charge to all county high school athletes and co-sponsorship of the Cobb County Symposium which continues to make a most gratifying contribution to community life in Cobb County and which this year, in addition to several outstanding guest speakers, will enjoy having Norman Cousins as the banquet speaker.

Following a period of active hospital expansion in the early 1970's, we have now seen a tendency toward retraction of such hospital bed expansion and the actual closing of a smaller facility thought not to be effectively contributing to the improvement of health care in the community.

Our Woman's Auxiliary under the vital leadership of Judy Kyburz has continued to make significant contributions to the welfare of the area. The ladies, through an aggressive C.P.R. program, have now trained a great number of police, community individuals, physician office staff members, and nearly all of the members of the Auxiliary themselves in effective cardio-pulmonary resuscitation. They are now, in association with Robert Session, compiling a manual to be utilized as a text for statewide C.P.R. programs. They continue to run the Gift Shop at Kennestone Hospital which this year contributed $70,000.00 to the institution to be used for library acquisitions and new equipment purchases. All of this in addition to significant contributions to the Symposium and to the AMA-ERF make the ladies an indispensable part of our organization.

With our new president, Phil Israel, having revitalized the committee structure of the Society, we look forward to 1978 as a year full of careful maintenance of old and proven projects and aggressive establishment and pursuit of new and necessary ones.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Cobb Evans J. Nichols Marietta	216	165	254	147

DEKALB COUNTY MEDICAL SOCIETY

Luther M. Vinton, M.D.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Dekalb Earnest C. Fokes Jr. Decatur	256	204	278	197

FLOYD-POLK-CHATTOOGA COUNTY SOCIETY

John I. Dickinson, M.D.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Floyd-Polk-Chattooga Peter Gilbert Rome	107	72	101	64

GEORGIA MEDICAL SOCIETY

Joseph A. Mulherin, M.D.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Georgia Medical Society Paul F. Jurgenson Savannah	220	202	236	193

MEDICAL ASSOCIATION OF ATLANTA

John T. Godwin, M.D.

I have attended all meetings of the Board of Directors during the period covered.

I have no suggestions at this time.

MEMBERSHIP

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Medical Association of Atlanta W. Ben Spearman Atlanta	1044	895	1205	840

MUSCOGEE COUNTY MEDICAL SOCIETY

Jack A. Raines, M.D.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Muscogee Conty Medical Society William C. Flanagan Columbus	176	127	202	136

RICHMOND COUNTY MEDICAL SOCIETY

Ronald F. Galloway, M.D.

Since my 1977 report, the Richmond County Medical Society has continued to be active. At regular meetings, various educational programs have been enjoyed by the membership. Attendance at the Society meetings remains good. The Board of Trustees meetings are well attended and considerable business accomplished. Membership has grown.

County and Secretary	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying	Members December 31, 1977 MAG	Members December 31, 1977 AMA Dues Paying
Richmond County Medical Society				
G. Rufus Maloney				
Augusta	326	271	353	283

COMMITTEE ON ALLIED HEALTH

J. Rhodes Haverty, M.D., Chairman

The Committee did not conduct any business during the past year, but it welcomes the suggestions of any MAG member about the training, credentialing, and practice of allied health professionals. Dr. Stephen Daniel, MAG staff for the committee, continues to serve as a member of the Georgia Society of Allied Health Professionals.

COMMITTEE ON THE AUXILIARY

Russell E. Andrews, M.D., Chairman

In the past, there has been no meeting of the Committee and this year there have been none. In April the 1977-78 year began. The Medical Auxiliary does more, gains more strength, shows that it can do more and be more needed and useful every year.

This past year each county has had their own programs, ideas and all their plans presented to the Committee were excellent. They have helped community relations by educating the children about immunizations, promoted CPR courses, diet control, cancer society help, aids in school allied health careers, GaMPAC, Disabled Doctors, and many other things. One of the most important is their ability to help in "legislative activities."

Next year with all they now take part in and with the increase in activities they will have, it will definitely work the Chairman of the Committee on the Auxiliary much more. This next year and the other coming years, I expect the MAG Committee on the Auxiliary will have to meet several times a year.

COMMITTEE ON COUNTERSUIT REVIEW

Henry M. Finch, M.D., Chairman

The Committee has not been active this year due to the fact that of the nine or ten inquiries we have had, not one has been able to meet the criteria for review and evaluation.

Half of the inquiries were presented by physicians whose suit had not been settled, and the others by physician defendants who could not, or did not, get the defense attorney to recommend countersuit due to malicious prosecution or for the filing of a groundless suit.

There is a need for the physician who has been sued to diligently seek the aid of his defense attorney insofar as groundless suits are concerned. Many suits are dismissed in the physician's favor because of improper investigation by the plaintiff attorney prior to filing a malpractice action suit.

CRAWFORD W. LONG MEMORIAL COMMITTEE

E. L. Frederickson, M.D., Chairman

The Committee has not had a formal meeting this year. However, the chairman has participated actively in the Board of Directors of the Museum, and we have continued to support the activities of maintaining the building in adequate condition. The last contract that was let was to finish pointing the bricks on the back of the building and to paint the inside of the building. Also, with the approval of MAG we are going to hire a consultant from another medical museum to function with the Board of Directors and the citizens of Jefferson in determining how to better present the museum to the community and to the country at large. This consultant will attend the next Board of Directors meeting, which will be during the week of Crawford W. Long Day, and meet as many people as possible at that time. It is hoped that this individual will then be able to spend a period of time researching what is available in this particular area that can be added to the museum, along with designs for improving all of the exhibit space within the museum. It is hoped that this work will be finished this summer.

COMMITTEE ON DISABLED DOCTORS

G. Douglas Talbott, M.D., Program Chairman

Introduction

The Medical Association of Georgia's Disabled Doctors Program had its inception in September of 1975 and currently is entering its 29th month of operation. As the results, subsequently tabulated, demonstrate its success has been extremely gratifying and the program has nationally been recognized. 42 physicians currently have returned successfully and happily to practice after identification, motivation, treatment, and reentry in the Medical Association of Georgia's Program. Physicians currently in treatment, involved programmatically, and graduated back in practice approach a total of 90.

History

In September of 1975 under the Council guidance and leadership of Dr. Earnest Atkins and Mr. Hank Holderfield of the DeKalb Medical Society the Disabled Doctors Program was initiated under the DeKalb Medical Society as a local effort. Later it passed to the state medical society with the acceptance of the program by the Medical Association of Georgia. Funding for 1976 by the Medical Association of Georgia for this program allowed experiential development. In 1977 the House of Delegates fully funded the Disabled Doctors Program. This full funding allowed the hiring of a medical director and a half-time program auxiliary coordinator and aftercare counselor. Concomitant with the adequate funding was the assumption of leadership by Dr. Cullen Richardson as Chairman of the Disabled Doctors Committee. Sub-

sequent organizational redevelopment in the program occurred which allowed a broad based participation by physicians in the administration in the functioning of the program. This is now growing beyond even optimistic projection and it is realistic to anticipate even greater success of the program in 1978 and 1979.

Organizational Structure

The organizational structure of the Disabled Doctors Program is composed of four committees which are diagrammatically presented in the enclosed sheet. The Council and the Executive Committee of the Medical Association of Georgia has the ultimate responsibility for the program. The Disabled Doctors Committee chaired by Dr. Cullen Richardson is the liaison between the Physicians Consultant Committee and the Council and has the daily responsibility administratively for the program. The Physicians Consultant Committee composed of members who are the confronters and aftercare liaison physicians of the program and by and large is composed of graduates of the program, although 30% of this committee are physicians who have not had the disease but are skilled in treatment of disorders of chemical dependency or emotional illness.

This committee is chaired by Dr. G. Douglas Talbott. Bi-monthly the Management and Treatment Team headed by Dr. James Mashburn meets. This committee is composed of treatment personnel at the facilities utilized in the program and the committee chairman decide on the progress and disposition of physicians currently in the program. Every three months the Disabled Doctors Committee and the Physicians Consultant Committee have a regularly scheduled meeting with agenda on Sunday at the Medical Association of Georgia headquarters to review the program, its policy, personnel, and progress on 90 day increments.

Disabled doctors entering into the program sign a contract which involves them and their immediate families in a four phase or four months treatment program. The last three months the patients are housed in the Atlanta area. Inherent in this agreement is 20 months of aftercare and surveillance. Phase I of the treatment program is a one month treatment course in one of the national treatment centers for chemical dependency or psychiatric disorder such as Hazelden, Ridgeview Institute, Willingway, Chit Chat, Menninger, or Smithers. Phase II is attendant upon the disabled doctor moving into an alternate living situation either in a halfway house or a three bedroom apartment while attending the DeKalb Addiction Clinic or Ridgeview Institute. Phase III and IV which compose the third and fourth months of treatment the disabled doctors work in the listed facilities which have been utilized in this program. These facilities are currently: (1) Georgia Mental Health Institute; (2) Peachtree Parkwood; (3) Salvation Army; (4) Ridgeview Institute; (5) St. Jude's Home; (6) Fulton County Alcoholism Center; and (7) South DeKalb Mental Health Center. Crawford Long Hospital has been utilized for several doctors in the Disabled Doctors Program who needed resharpening of their specialty and clinical skills before returning to practice.

Program Activities

Weekly program activities include:

1. The Caduceus Club meeting every Tuesday night for Georgia's disabled doctors and their spouses. This 90 minute session allows communication and liaison between physicians in all phases of the program and those associated with the program. The format varies weekly.
2. Structured education groups meet for one hour prior to the Caduceus Club on a weekly basis. These include those physicians in treatment phases, graduates of the program who are back in practice and still a third group for the spouses.
3. Saturday morning a transitional group meeting is held at 8:30 where the doctors who have been promoted to Phase III and IV dialogue with the physicians still in the treatment phases.

In addition to the weekly activity program there is an annual weekend retreat for physicians associated with the Disabled Doctors Program. This year in February, Cohutta Lodge in Chatsworth, Georgia was the site of the retreat. Last year Unicoi Lodge at Helen was utilized. Each summer a one day retreat is scheduled. In 1977 Dr. Mashburn's home in Cumming, Georgia served that purpose.

The International Doctors in Alcoholics Anonymous (I.D.A.A.) is an international forum, both educational and therapeutic, in which a number of doctors in the Georgia program have attended both on a regional and national basis. Several national schools on alcohol and drug rehabilitation have been utilized as has been educational trips by several of the physicians still in treatment to the national treatment centers. Involvement with the junior medical students at Emory University by the disabled doctors both in the patient phase and under supervised teaching situations is part of the program. Attendance and participation in the nine week educational lecture on "Alcoholism and Drug Addiction, A Family Disease" at Ridgeview Institute is also a component of the on-going program activities.

Results of the Program

The results to date of the program are summarized in the following chart as of February 13, 1978:

Contacted and Verified	86
Entered Treatment	67
Returned to Practice	42
Currently in Treatment	16
Repeating Treatment	8
Broken Contracts	3
Deceased	1

It is significant to point out that as of February 13, 1978 42 physicians have returned to practice.

Currently one-third of the doctors in treatment are out of state physicians while two-thirds of the doctors are from Georgia. Approximately three out of four of the impaired physicians currently being treated are afflicted with the disease of alcohol and drug addiction while a quarter of those physicians are primary psychiatric disorders.

Present Program Status

The above data reflects the success to date of the Medical Association of Georgia's Disabled Doctors Program. However, the administration and programmatic staff are sensitive to the fact that this is an experiential program without precedence in this country. Therefore this program requires considerable refinement and sophistication on a week to week basis. There is no doubt, however, that Georgia has assumed national leadership in the Disabled Doctors Program and currently Dr. Richardson and group

of program physicians are working with the Director of Mental Health of the American Medical Association on a regionalization program for the United States which will involve disabled doctors. In addition, Georgia is currently providing numerous states and most of Georgia's neighboring states with counsel and consultation in setting up their own disabled doctors programs.

The results in Georgia and subsequent national leadership has been made possible by the financial support of the Medical Association of Georgia, its House of Delegates, the Committee members, and Council. With this growth of the program it is urgently requested that the Medical Association of Georgia support the reduced annual budget for 1978-79 for the Disabled Doctors Program.

COMMITTEE ON LABORATORY QUALITY

Richard E. DuBois, M.D., Chairman

This year's activity by the Laboratory Quality Committee has been negligible. Efforts during the first six months of the year to find funds, either from private sources, such as the Ford Foundation, etc., or from Federal funds, such as the Bureau of Quality Assurance, were unrewarding. Lacking sufficient funds to back our efforts, we have had no subsequent meetings and have had no meaningful activity.

An aggressive program had been planned. We had proposed to enroll Georgia's physicians who engaged in private practice and who had a laboratory into proficiency testing programs, such as that sponsored by the College of American Pathologists or the American Society of Internal Medicine. It had been hoped that feedback from such proficiency testing programs and the quality control efforts, which, understandably, go hand in hand with proficiency testing, would allow the Committee to assess the quality of laboratory performance in the individual physicians' offices.

Such an assessment would allow for a planned program of education, not only to physicians who have laboratories in their offices but to the personnel in those laboratories responsible for the performance of tests. The educational efforts were proposed to be on a level geared for the individual performing the studies. This meant all the way from office secretaries, if they were performing studies, to highly skilled registered laboratory technologists. It was proposed to provide a register of all teaching and educational programs relevant to laboratories which were to occur within the State of Georgia. Many different specialty and subspecialty societies and laboratory equipment merchants provide such seminars and programs that could often be overlooked by those very people who need the programs the most. The register of programming would allow physicians to schedule continuing education programs for their personnel.

It was further proposed that a voluntary group of Georgia pathologists participate in telephone conversations on an "on-call" basis to aid laboratory directors who are in need of advice, so that problems could be solved when they arose, rather than being delayed.

It was also proposed to provide a "lab mobile" equipped with equipment which could travel from county to county with advanced programming and skilled personnel to give on the spot training to the laboratory teams in various locations participating in physician office laboratories.

In summary, it was proposed to involve all of Georgia's physicians in a program of proficiency testing, which would start the full circle of testing, assessment, education, and continuing thereafter. Done as a voluntary program with full participation, it could have been a great deal of benefit to individual physicians, to the image of medicine in the State of Georgia, and to the impact of our medical society on the national medical/political scene. It would have provided us with concrete evidence of consumer protection in an area where physicians' offices have been challenged in the past.

The funds were not available and there was negligible voluntary participation by physicians in proficiency testing programs.

LIAISON COMMITTEE TO THE GEORGIA STATE MEDICAL ASSOCIATION

Ronald F. Galloway, M.D., Chairman

No problems have arisen during the past year requiring a formal meeting of my Committee. As far as I am able to determine, relations between our Medical Association of Georgia and Georgia State Medical Association continue to be good.

COMMITTEE ON MEDICAL PRACTICE

W. Dan Jordan, M.D., Chairman

The Committee on Medical Practice has had a relatively quiet year. One project was discussed at some length, and this was the proposed Blue Cross Utilization Review program that had been under study by the Blue Cross/Blue Shield of Atlanta for approximately nine months. This program consisted of the implementation of a review process to be carried out at the hospital level to determine the cost effective use of medical resources in accordance with the contracts of the Blue Cross/Blue Shield subscribers. The study reviewed such items as lengths of stay, promptness of services, the medical necessity of admissions and services, discharge planning, pre-admission testing, and any other matters or procedures which would minimize unnecessary use of hospitalization. It was anticipated that the performance of this activity would be carried out by the Hospital Utilization Review Committee.

The pilot study done in ten participating hospitals in the North Georgia area was evaluated by the Blue Cross/Blue Shield Company, and it was their conclusion that the implementation of a Utilization Review program of this nature would result in between 5 and 6% reduction in the number of hospital days. For this reason it was anticipated that Blue Cross/Blue Shield would require their participating hospitals to include this type of utilization review into their participating hospital agreement effective in January, 1978.

The Medical Practice Committee discussed this issue with representatives of the Blue Cross (some of whom are members of the committee) and after further discussion the committee approved the following motion.

"Analysis of the data submitted concerning the Blue Cross Utilization Review project indicates that a considerable saving may be realized by instituting utilization review and that this may be done without sacrificing the

quality of care. Because we should all be concerned with cost containment, we would accept this project as outlined to us. We would like to review the data after one year or reasonable period of operation.''

This motion was then forwarded to the Executive Committee for their final decision.

Other activities of the committee have included the monitoring of the development of further standards of accreditation by the Joint Commission on Accreditation of Hospitals. These drafts are mailed to the committee chairmen for their evaluation and if there seems to be a problem area, it is submitted to the full committee. No meetings were held on this type activity during the past year.

The committee would like to re-emphasize its commitment to participate in reviewing the Medical Staff Bylaws of any hospital medical staff upon request by members of the Association. We have had and hope to continue to have a small reserve fund for legal interpretations of these matters should they arise.

Recommendations: None.

COMMITTEE ON MENTAL HEALTH

William S. Davis, M.D., Chairman

This year the activity of the Mental Health Committee has focused chiefly around our efforts to have significant input into the Governor's Advisory Committee on the changes in the Georgia Mental Health Code. By working with individual members of the Governor's Committee, we did have significant input into what has turned out to be the final draft of a bill which your Committee feels is generally acceptable and which will be workable in practice. We have worked with the Georgia Psychiatric Association to elicit support for a bill to be introduced which would help to foster broadening of insurance coverage for mental illness.

Your Mental Health Committee would like all interested MAG members to be aware that the Annual Meeting of the American Psychiatric Association will be held in Atlanta at the World Congress Center, May 8-12, 1978. The program is extensive and covers a very broad range of topics which should be of interest to many MAG members.

COMMITTEE ON OCCUPATIONAL HEALTH

Robert P. Cunningham, M.D., Chairman

There was one change in the composition of the committee with the addition of Kenneth T. Woodsides, M.D., following my recommendation of September 13, 1977 to Dr. Earnest Atkins.

Four members of the committee attended the August 23, 1977 meeting of the Georgia Occupational Medical Association. Mr. Al Crenshaw, former Director of the Georgia Workmen's Compensation Board, and Mr. George DeMore, Vice President of the Georgia Business and Industry Association, presented the program on Workmen's Compensation.

Dr. Kenneth Woodsides attended the AMA Congress on Occupational Health held in St. Louis on September 19-20, 1977. At that meeting Dr. Robert Bennett received the Physician's Award, an annual award by the President of the Committee on Employment of the Handicapped.

COMMITTEE ON PHYSICIAN-LAWYER LIAISON

William E. Huger Jr., M.D., Chairman

The chairman of the MAG Physician-Lawyer Liaison Committee and his opposite number, Mr. Ogden Doremus, Georgia State Bar, have met and reviewed a number of items which are of common interest to both physicians and attorneys. Among these items are such subjects as Lien Law, Medical-Legal course in the Medical School curriculum, and a Risk Management course taught jointly by the Georgia State Bar Association and St. Pauls Insurance Company. These and other subjects are being investigated.

It is the intention that a joint meeting can be held again between the Committee Chairman and the appropriate Legislators so that proper action can be taken within the year.

PHYSICIAN-LAWYER LIAISON COMMITTEE

William E. Huger Jr., M.D., Chairman

Mr. Ogden Doremus and myself have met concerning revitalization of the Committee with a number of problems involved regarding both doctors and lawyers. This varies from a Risk Management Course in the medical schools to a Lien Law protecting the physician as is in existence for the lawyers.

Our meeting was in my opinion, very fruitful. Our intent is to call upon the other members of the Committee during the year for discussion of those subjects agreed upon by Mr. Doremus and myself plus any additional recommendations the Committee may have.

Whether a final report will be available at the time of the MAG meeting April 14 is in question.

COMMITTEE ON PUBLIC HEALTH

J. Gary Palmer, M.D., Chairman

In 1977 the Public Health Committee of the Medical Association of Georgia continued to act in a Liaison capacity. Throughout the year members attended several meetings sponsored by the Department of Human Resources. Those meetings were primarily concerned with the decreasing level of immunization against communicable childhood diseases.

The Department of Human Resources is to instigate a program entitled, ''Operation Catch Up,'' and has requested cooperation from the medical community.

The Committee on Public Health drafted a resolution and submitted it to the MAG Board of Directors for endorsement. This resolution requested that the MAG actively participate in the National Immunization Initiative sponsored by the American Medical Association and the allied state medical associations. The resolution requested that the MAG, through the county medical societies, participate fully in the campaign to raise the immunization level of Georgia's children.

There are no other specific recommendations of the committee. The committee would, however, continue to work in the capacity of a consultant to the activities of the Department of Health, Education, and Welfare, as well as the Georgia Department of Human Resources.

COMMITTEE ON SCHOOL CHILD HEALTH

Alan J. Sievert, M.D., Chairman

I accepted the chairmanship of the School Child Health Committee for MAG during the fall of 1977. The previous Committee had no unfinished business from last year and the Committee has been inactive so far this year.

COMMITTEE ON TRANSFUSION AND TRANSPLANTATION

Frank Matthews, M.D., Chairman

There has been much sound and fury in the past year at the national level about transfusions. However, little, if any, productive work has emerged. It is the opinion of your committee chairman that regardless of the final form of American Blood Commission regulations, the State of Georgia will have little difficulty in implementing them. However, since no definite course of action has come from the national arena, there are no recommendations by your committee.

AD HOC COMMITTEE ON PUBLIC RELATIONS

E. R. Jennings, M.D., Chairman

This is the annual report of the Public Relations Special Committee which was appointed by Dr. Perry approximately three months ago.

The Public Relations Committee has attempted to utilize the services of a new Director of Public Relations, Mr. Ken Williams. Mr. Williams has done an excellent job of releasing newspaper and radio stories to tell of the attitudes and accomplishments of the doctors of the State of Georgia. He has encouraged doctors throughout the state to send in any derogatory articles for his rebuttal. In addition, he has published some feature articles which have been written by members of The Medical Association of Georgia.

A very effective part of the program has been the widespread coverage of Dr. Perry's presentation challenging the accuracy of Mr. Califano's statements about doctors. This has resulted in a rather noticeable change in recent weeks in releases from the Secretary of Health, Education and Welfare.

The Public Relations Committee requests that all doctors utilize The Medical Association of Georgia as a sounding board of their accomplishments and as a media to counteract any unfair criticisms of their medical care.

It is hoped that an ongoing program with widespread news releases will tell the proper story of the role of the doctor in Georgia.

AD HOC COMMITTEE TO STUDY BUILDING AND LAND

Frank G. Eldridge, M.D., Chairman

This Committee has had one formal meeting this year, at which we voted to recommend to the Board of Directors that 20% of the original mortgage on our building at 938 Peachtree Street be paid, since we were paying 7½% interest on the mortgage and receiving some 5% to 6% on our funds invested. The Board of Directors adopted this recommendation and $111,713.47 was paid on the mortgage in September of 1977.

For the fiscal year 1976-77, $46,550.00 was placed in a restricted fund for future use in securing land and buildings. This money earned $1,713.59 in interest since being deposited. The balance in the restricted fund is $48,263.59.

GEORGIA MEDICAL CARE FOUNDATION

Jack F. Menendez, M.D., President

There have been several changes in the Georgia Medical Care Foundation since our last report, reflecting the growth and diversification of the Foundation; Mr. Bob Diprova resigned as the Associate Executive Secretary on July 1, 1977, to assume a substantial position with a private corporation in the Atlanta area. He has been replaced by Mr. Bill Minor who comes to us from the Southern Health Foundation in Tampa, Florida.

The Foundation now operates a total of 17 Specialty Panels including panels for Long Term Care, Psychology, Podiatry, and most medical specialties. The voluntary participation by the members of these panels (including Osteopathic physicians) is great, and the entire Medical Association owes them a vote of gratitude for the work that they have done. Secondly, the Foundation has been headed for the past year by the following slate of officers: Jack F. Menendez, M.D., President; Luther M. Thomas Jr., M.D., Vice President; John R. McCain, M.D., Secretary; and Michel A. Glucksman, M.D., Treasurer; and a very active Board of Directors. It should be noted that Dr. William Hardcastle of Decatur retired from the Board of Directors in January and was replaced by W. Earl Bobo, M.D., also of Decatur.

The Hospital and Physician Departments, which had functioned as a single unit were separated in order that each might grow and develop at a more rapid rate and deal with problems particular to each. This gives the Foundation four major operational departments: Hospital Services, Physician Services, Long Term Care Services, and Administration. These are headed respectively by: Lynn Myers, R.N.; Anita Anderson, R.N.; Polly Stanley, R.N.; and Mr. Minor. Each of these Department Managers has functioned extremely well in these roles and is to be congratulated. A summary of the reports of the activities of each of these Departments follows:

Hospital Service

In 1977, the number of claims received from Medicaid for hospital review was substantially below that for which we were contracted. A total of 1,892 claims were received, of which 1,180 were approved and 180 were either reduced or disallowed. The balance represents work-in-process and duplicate claims received. Additionally, the Hospital Department has participated in several special projects at the request of Medicaid but has not had any follow-up from Medicaid on these. Commercial hospital claims reviewed fell into two main categories: Atlanta Blue Cross/Medicare-A, and review of individual claims and institutional patterns of practice at the request of private insurance companies in the State of Georgia. The number of claims received from Atlanta Blue Cross increased substantially over those received in prior years, but the Foundation remains unable to establish any sort of working relationship with Columbus Blue Cross.

As directed by the MAG Board of Directors, and in compliance with the directive of the House of Delegates, the Foundation submitted its application for a Planning Grant to assume the duties of a statewide PSRO on December 16, 1977. We expect to be able to report to you during your Annual Session the results of this Planning Grant application and our current PSRO status.

Finally, the Hospital Department has been quite active in speaking with county medical societies, hospital medical staffs, insurance companies, and major employers for the purpose of promoting a better understanding of the Foundation and its hospital review process. It is our hope that this will contribute to an increased amount of private review for the Foundation in the coming year.

Physician Services

During the past year, the Foundation reviewed a total of 21,812 individual Medicaid claims. This amount is substantially below that for which the Foundation is contracted, and continues the slump noted in our report last year. The causes of this reduction and the number of claims seen appear to be multiple and best discussed orally. Contributing to the decline in claims received, however, has been the change-over in Medicaid's procedure for forwarding claims to us by microfilm with computerized indices. To date, we are still receiving a small sample of the total physicians claims submitted to the Medicaid Program.

In the commercial review area, the number of claims received has increased substantially. Review undertaken for Atlanta Blue Shield amounted to nearly 1,300 claims, while total review came to almost 1,500. Progress has been made toward the establishment of a working contract between the Foundation and Prudential Medicare-B and I hope to be able to report a signed contract to you when the House of Delegates convenes.

CHAMPUS claims reviewed by the Foundation have also increased substantially over the prior years, although what the situation will be when MAG is no longer the CHAMPUS intermediary remains to be seen.

Finally, with regard to the coming year, goals established for the Physician Services Department include a complete documentation of procedures involved in the administration of work-in-process in the department, based on current information and, hopefully, the establishment of a drug review program within the Medicaid Peer Review contract.

Long Term Care Services

The traditional nursing homes programs of past years have continued during this year, but at a higher level of activity. This includes semi-annual reviews of a total of 305 nursing facilities in the State of Georgia with approximately 23,700 patients reviewed during each semi-annual period; continuation of the telephone based pre-admission certification program with a total of nearly 7,000 placements made by this mechanism; performance of utilization review for all Medicaid nursing home facilities; and medical care evaluation studies for all Medicaid nursing homes in the State of Georgia. In addition to these older programs, two new programs and one special project have been undertaken during the past year. The Nursing Home Bed Registry, the Home Health Review Program, and the Psychological and Psychiatric Review Program.

The Nursing Home Bed Registry is an on-going program that will be of great use to all physicians treating nursing home patients throughout the State of Georgia. By calling on a special WATS line number (1-800-282-4573) the physician or hospital discharge planning staff will be able to find the name of the nearest nursing facility where an appropriate vacancy is available, the appropriate level of placement for the patient being considered for transfer to another nursing facility, and additional information that will be of use in the discharge and transfer of long term patients.

The Home Health Care Review Program was established to monitor and evaluate services provided by the non-profit home health agencies in the State. The program is designed to assess the appropriateness of services provided to Medicaid patients as well as necessity, quality, and adequacy of such a program. It also assures that the services provided are those prescribed and monitored by a physician, and that the physician is provided with appropriate reports of progress by Home Health Agency. This program is conducted by means of both in-agency reviews of patients' records and occasional visits with the patients themselves.

The Psychological and Psychiatric review program is a one time project undertaken by the Foundation at the request of Medicaid to provide for the Psychological and/or Psychiatric evaluation of approximately 3,000 mentally retarded or psychiatrically disabled individuals who were placed in nursing homes prior to January 1, 1976, without the performance of these federally mandated evaluations. Working through the Georgia Psychological Association and the Georgia Psychiatric Association, all of these evaluations will be completed in the course of one year.

Administration

Aside from the changes in organizational structure noted at the start of this report, the bulk of the work in this Department has been devoted to the installation of a computer microfilm storage and retrieval system for all of the Foundation's records and claims. A considerable amount of time and effort has been expended in installation of this system on the MAG computer and it is now beginning to bear fruit.

Financially, the Foundation operated during this past year on a budget of approximately $1.5 million, an increase over last year, but this does include a one-time cost of performing the Psychological and Psychiatric Review Program. During the coming year we expect to see an extension of our standard Medicaid review contract, the addition of a dental review program and, of course the beginning of the PSRO Planning Grant.

I shall be happy to answer any questions that you might have concerning this report with the Foundation at the appropriate Reference Committee meeting.

AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Russell E. Andrews Jr., President
Auxiliary to the Medical Association of Georgia

The 1977-78 Auxiliary year commenced when the orientation meeting was conducted during the annual convention last April. At this time, the Auxiliary theme was

announced—unity for service; to serve in unity with those seeking better conditions, better understanding and medical-community relationship.

The idea of unity has been foremost in our minds this year. Unity in working together as volunteers for the common cause of medicine, and in assisting our physician husbands in reaching into the community to inform patients that the aim of the medical profession is to provide the best available health care at the lowest possible cost.

The Auxiliary was challenged to play a leadership role in assuring that all children are vaccinated against communicable diseases. This challenge was issued in June during the Auxiliary to AMA annual convention in San Francisco, California. Georgia delegates have proceeded to implement the "Hopscotch Program" throughout the needed school areas. Many schools now have painted hopscotch courts with communicable diseases printed in each square, hopefully making the children and subsequently, their parents, more aware of the need for proper immunization. Radio, television, and newspaper coverage has been employed to promote awareness in our individual communities. The Georgia Department of Human Resources has organized a statewide campaign called "Operation Catch Up." The Auxiliary members are actively supporting both of these programs to assist in raising the immunization level of Georgia youth.

The summer Executive Board Leadership Conference was conducted in Rome during July. Programs were presented on safety, health education, GaMPAC, Parliamentary Procedure, Disabled Doctor's Program and basic communications.

The winter Executive Board meeting was held in Columbus in January, 1978. A report of the AMA Leadership Confluence, presented for county Presidents-elect and State Presidents and Presidents-elect in Chicago during October, was given and each county President has the opportunity to share the goals and projects of her Auxiliary. Mrs. M. Bruce Martin, President of the Women's Auxiliary to the Southern Medical Association, presented the awards for the observance of Doctor's Day and the contributions to Research and Romance of Medicine to the winning county auxiliaries.

Throughout this year, doctors' wives have been engaged in programs to promote better health care for the American people. Cardiopulmonary resuscitation courses are continuing; introduction of Heimlich Maneuver in schools; nutrition programs on low fat-low cholesterol cooking; scholarships in health related fields; rolling bandages for the Cancer Society; visual and hearing screening in the schools; puppet shows are presented concerning drug abuse and "improving one's image" for eighth and ninth graders; continued sponsorship of the Language Bank and the newly created Bank for the Deaf; legislation has been uppermost in many Auxiliary programs, consistent with the awareness of the stance on health issues. This is not a full account of the Auxiliary activities, but provides a brief insight to what the Auxiliums are accomplishing in their areas.

The Allied Health Careers Clubs of Georgia have continued to grow and the response of interested students continues to emerge.

Someone has said, "how good and pleasant it is for brethren to dwell together in unity." The idea of unity as expressed last April has indeed not been lost. Support from the Medical Association of Georgia Board of Directors and the membership is greatly appreciated. There has been demonstrated a definite feeling of being needed and useful to our medical societies this year. When I, as well as others, have visited with you, we have felt at home and united with you and your endeavors. For this, I thank you.

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Edgar Woody Jr., M.D., Editor

Content

During the 1977-78 year, we have continued in our efforts to be responsive to the needs and desires of our readers. In line with this policy during the year just past, we devoted six out of 12 issues to specific subjects which we felt were of current concern to our members.

The May issue presented a collection of papers devoted to a comprehensive evaluation of cost containment. This issue received national recognition and requests for reprints were received from many parts of the country. The June issue, as in the past, presented annual reports along with Annual Session procedures. The October issue was devoted to practice management. In November, the education issue appeared and featured 23 pages of information on educational activities throughout the state. Seven physicians contributed reports to this section. In January, summaries of testimonies by 12 Georgia physicians appearing at national health insurance hearings were presented. In February, the program for the Annual Session was presented.

Credits

Our contributing editors continue their helpful functions in soliciting and reviewing scientific papers for publication. We feel fortunate to have added Dr. Calhoun Witham of the Medical College of Georgia to our staff of contributing editors.

The Executive Committee of the Board of Directors, which also functions as our Publications Committee, as always, has been helpful in guiding the affairs of the *Journal*. Our Heart and Cancer pages have continued their excellent legal pages for the *Journal*.

Bob Hamill, our veteran cover artist, continues with his uncanny ability to come up with unusual covers month after month, with a minimum of coaching.

Dr. J. G. McDaniel, editor of the feature page "I've Told This Before," seems to come up with better stories each month. In addition to original humorous material, the page has recently featured very significant historical material. This page enjoys quite a large following.

The fine contributions and useful input by members of the headquarters office staff constitute an essential element in the production of each issue of the *Journal*.

Personnel

In October of 1977, we were fortunate to be able to hire Caffilene Allen as Assistant Managing Editor. She is a Georgia State University student in journalism and is a recipient of the Women in Communications scholarship. She maintains a 3.65 average at Georgia State. The need for an additional person in the *Journal* office was felt when it was decided to initiate a vigorous drive for local and state advertising in an effort to supplement revenues from national advertising sources.

Local Advertising

Since the initiation of our local advertising program, we have obtained the full-time services of Mary Coté who functions as our advertising representative statewide. She works on a straight commission. During our current fiscal year, as of February 1, 1978, our local and state advertising billing has increased 250% over the same period a year ago. It is hoped that these present trends can be sustained.

State Medical Journal Advertising Bureau

Since last year, the Williams Wilkins Company of Baltimore has taken over responsibility as the national sales force for the Bureau. Although their preliminary results have not been spectacular, they have succeeded in halting the steady decline in national sales revenues and have shown between 5 and 10% increase in total bookings in the past year. Projected estimates would suggest that we may expect this trend to continue during the coming year. Since your editor serves as a member of the Board of Directors of the Bureau, it has been my privilege to evaluate this sales force at close range. It is my opinion that they are functioning well in our behalf.

New Business

The Speaker proceeded to new business, calling for the introduction of resolutions.

(R1) Rural Health Clinics—Withdrawn
(R2) Medicaid Fraud and Abuse Audit (1976)—B
(R3) AMA Opinion Poll Regarding National Health Insurance—C
(R4) Certificate of Need—B
(R5) Balancing the Federal Budget—C
(R6) Social Security Tax—C
(R7) Peer Review—B
(R8) House Bill 1294—Laetrile—C
(R9) Health Systems Agency—A
(R10) Constitution & Bylaws—Constitution & Bylaws
(R11) Constitution & Bylaws—Constitution & Bylaws
(R12) Rural Health Clinics—A
(R13) Utilization Review Process—B
(R14) Federal Employees Insurance Program—B
(R15) Peer Review Network—B
(R16) HMO-IPA—B
(R17) Health Maintenance Organization-Independent Practice Association—B
(R18) United States Congress—H.R. 1818—C
(R19) Proposed Changes in Code of Ethics—A
(R20) Summary Report of AMA Commission on Cost of Medical Care—F
(R21) Private/Public Health Care Systems—A
(R22) National Health Insurance—C
(R23) Definition of Supervision of Physician Extenders—B
(R24) Policy Statements—Withdrawn
(R25) Health Systems Agency—A
(R26) Full-time Health Planner—B
(R27) Misrepresentation by Third Party Carriers—B
(R28) Smoking in Health Care Facilities—D
(R29) National Commission on Cost of Medical Care—F
(R30) Nurse Practitioner—B

The Speaker then adjourned the First Session of the House of Delegates at 11:55 a.m.

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Delegates prepare to listen to and debate over reference committee reports.



Second Session House of Delegates

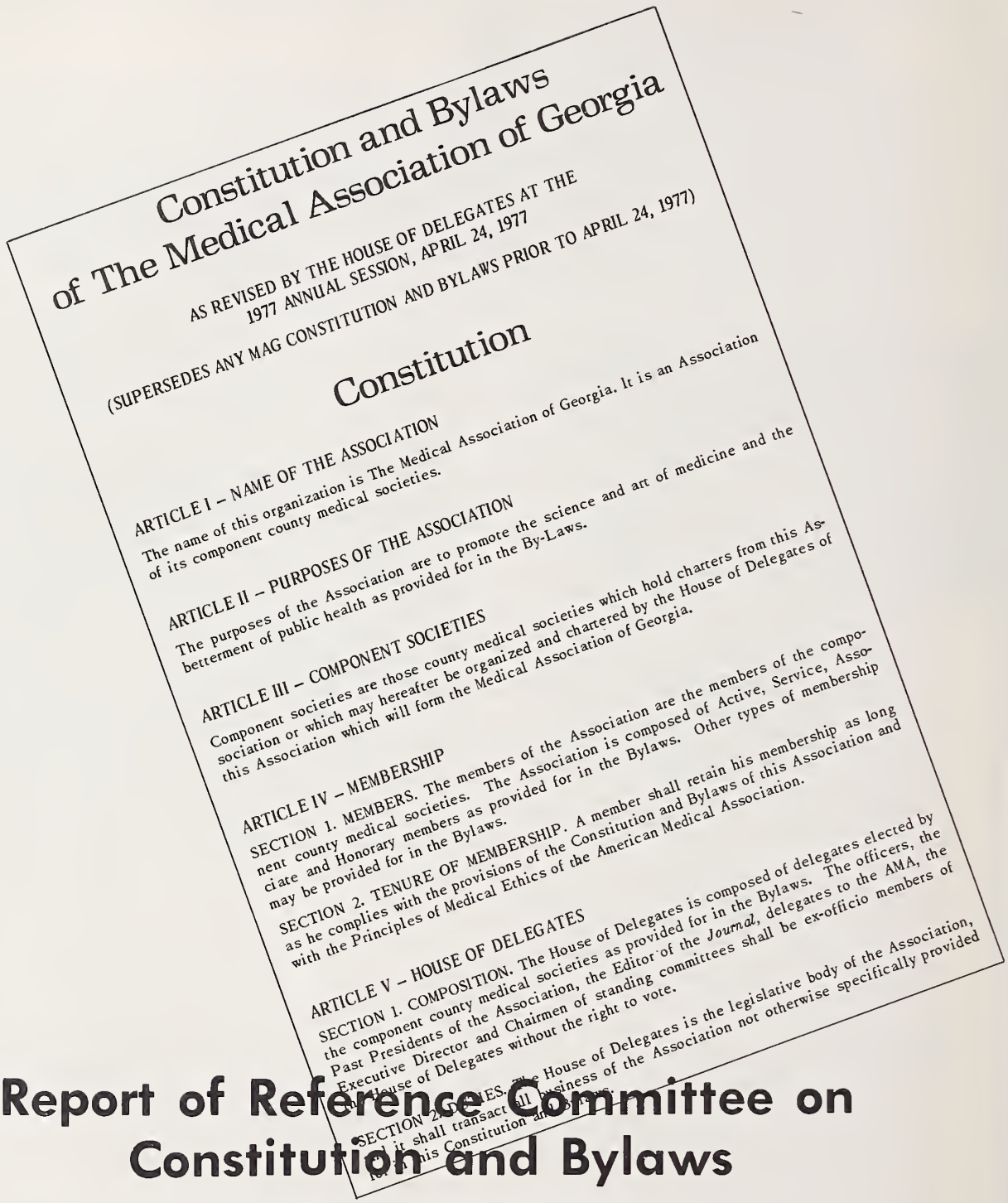
Saturday, April 15, 1978

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia, 1978 Annual Session Business Meeting, was called to order at 12:30 p.m. on Saturday, April 25, 1978, by Speaker L. C. Buchanan, Decatur, in Colony Hall at the Holiday Inn in Jekyll Island, Georgia.

Speaker Buchanan asked for a report on attendance from Dr. Hugo S. Moreno, chairman of the Credentials Committee, and it was reported that 182 duly-elected delegates representing 47 component county medical societies were present for the Second Session. Accordingly, a quorum existed.

Reference Committee Reports

Speaker Buchanan called for reports from the reference committee chairmen. The Speaker restated the procedure that would be followed and then proceeded to call for reports from reference committees:



Constitution and Bylaws
of The Medical Association of Georgia

AS REVISED BY THE HOUSE OF DELEGATES AT THE
1977 ANNUAL SESSION, APRIL 24, 1977

(SUPERSEDES ANY MAG CONSTITUTION AND BYLAWS PRIOR TO APRIL 24, 1977)

Constitution

ARTICLE I – NAME OF THE ASSOCIATION

The name of this organization is The Medical Association of Georgia. It is an Association of its component county medical societies.

ARTICLE II – PURPOSES OF THE ASSOCIATION

The purposes of the Association are to promote the science and art of medicine and the betterment of public health as provided for in the By-Laws.

ARTICLE III – COMPONENT SOCIETIES

Component societies are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered by the House of Delegates of this Association which will form the Medical Association of Georgia.

ARTICLE IV – MEMBERSHIP

SECTION 1. MEMBERS. The members of the Association are the members of the component county medical societies. The Association is composed of Active, Service, Associate and Honorary members as provided for in the Bylaws. Other types of membership may be provided for in the Bylaws.

SECTION 2. TENURE OF MEMBERSHIP. A member shall retain his membership as long as he complies with the provisions of the Constitution and Bylaws of this Association and with the Principles of Medical Ethics of the American Medical Association.

ARTICLE V – HOUSE OF DELEGATES

SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component county medical societies as provided for in the Bylaws. The officers, the Past Presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and Chairmen of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

SECTION 2. DUTIES. The House of Delegates is the legislative body of the Association, [illegible] it shall transact all business of the Association not otherwise specifically provided for in this Constitution and Bylaws.

Report of Reference Committee on Constitution and Bylaws

J. A. RAINES, M.D., Chairman
RICHARD C. MATTISON, M.D., Vice-Chairman

Chairman Raines reported that the Reference Committee on Constitution and Bylaws met on Friday, April 14, 1978, in Colony Hall at the Holiday Inn on Jekyll Island and considered the items referred to it.

He expressed his appreciation to the members of the Reference Committee who were present: J. A. Raines, M.D., Columbus, Chairman; Richard C. Mattison, M.D., Decatur, Vice-Chairman; Donald C. Abele, M.D., Augusta; Richard A. Griffin III, M.D., Cartersville; Thomas J. Anderson Jr., M.D., Atlanta, and Charles R. Richardson, M.D., Statesboro.

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D., Chairman

Item 1. Resolution 14 (1977)—The right of referendum and petition.

RESOLVED, that the House of Delegates of MAG in Annual Session in April, 1977 accept the following as a proposed amendment to the Constitution of the Medical Association of Georgia:

ARTICLE XIV

The right of referendum and petition shall be as set forth in the Bylaws of the Medical Association of Georgia.

AND, BE IT FURTHER RESOLVED, that the House

of Delegates of MAG in Annual Session in April, 1977, instruct the Constitution and Bylaws Committee to develop a provision within the Bylaws of MAG to accomplish the above resolution requiring signatures of at least 10% of the membership and requiring suitable geographic representation of the petitioning members.

REFERENCE COMMITTEE RECOMMENDATION:

Your Reference Committee felt that the concept of petition and referendum as proposed by the Resolution has merit. However, the Resolution is vague and ambiguous and the actual mechanism needs more study development before an informed decision can be made.

Mr. Speaker, your Reference Committee recommends that the Resolution 14 be referred to the Constitution and Bylaws Committee for further study and recommendation.

HOUSE OF DELEGATES ACTION—Voted to refer as recommended by the Reference Committee.

The Constitution and Bylaws at the present time (Article VII—Meetings—Section 3—Special Meetings) states special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Board of Directors or upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.

It is clear that the Constitution of the Medical Association of Georgia at the present time recognizes the right of Referendum and Petition. Therefore, it appears that those submitting the Resolution would like to establish a mechanism by which a smaller minority (suggested 10%) might enforce a reconsideration of policy established by the House of Delegates.

There are also many other ways that policy changes may be brought before the House of Delegates, i.e., through officers, committees, county societies, etc., but these mechanisms were apparently not the intent of the Resolution.

The Constitution and Bylaws Committee is opposed to this change. The Right of Referendum and Petition now exists in the Constitution and that 25% of the membership is a reasonable percentage.

Should the House of Delegates desire a change in this percentage, a resolution should be passed specifying the percentage desired and the Constitution and Bylaws Committee will draw the necessary language.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 14 was submitted to the 1977 House of Delegates which subsequently referred this Resolution to the Standing Committee on Constitution and Bylaws for study and recommendations. That resolution proposed an additional method by which the general membership might petition for a called meeting of the House of Delegates. The current annual report of the Constitution and Bylaws Committee opposes this change. Your Reference Committee reviewed the several mechanisms now available by which a called meeting of the House of Delegates can be scheduled. The proposal under Resolution 14 would require 10% of the general membership which would be in excess of 400 members. Under our current procedure, ⅓ of the membership of the House of Delegates may request a called meeting. This is numerically a much smaller number. Furthermore, it was the opinion of your Reference Committee that lacking the support of even ⅓ of the House of Delegates, there would be little reason to schedule a called meeting for the House of Delegates. Your Reference Committee also agreed with the additional reasons contained in the annual report of the Committee on Constitution and Bylaws. Your Reference Committee would, therefore, advise the House of Delegates to support the recommendations of your Constitution and Bylaws Committee.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Committee on Constitution and Bylaws.

NOTE: Existing wording appears here as is. Suggested amendments by **addition** are indicated by **boldface type.** Amendments by *deletion* are indicated by *italicized type*. It is possible to read the wording as it is suggested. Only those sentences preceding and succeeding a suggested change that help identify the suggested amendments are shown here.

Item 2. RESOLUTION 19 (1977)—Redefinition of associate membership.

WHEREAS, organized medicine should be greatly benefited by the active participation of state and county health officers and members of full-time medical faculties.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 19 would amend the Bylaws to exclude state and county health officers and full-time members of the medical faculties from Associate membership. It would require these categories to be active members. The Committee agrees in principle with the concept that these categories of physicians should be active MAG members.

Mr. Speaker, your Reference Committee recommends that Resolution 19 be referred to the Committee on Constitution and Bylaws for their consideration and development of appropriate wording to accomplish the principle set forth in the Resolution.

HOUSE OF DELEGATES ACTION—Voted to refer Resolution 19 to the Committee on Constitution and Bylaws for consideration and development of appropriate wording.

The Constitution and Bylaws Committee is opposed to this change for several reasons.

1. An M.D. member who is licensed in the State of Georgia and a member of a medical school faculty, may become an active member of MAG at the present time.
2. The requirement that a faculty member become an active member of MAG would create a feeling of being pressured and in all probability cause some who are now members to drop their membership.
3. A license in the State of Georgia is not required to teach in a medical school, but be required for active membership.
4. Under the present Constitution and Bylaws, an associate member may serve on a committee and participate on other activities, but cannot vote or hold office. Many faculty members both now and in the past have contrib-

uted a great deal in time and knowledge to MAG.

In studying this matter your Committee found that there is an increasing number of Ph.D.s teaching in our medical schools. We feel that a mechanism should be studied by which the Medical Association could receive some benefit from their expertise and influence in teaching younger physicians.

Should the House of Delegates decide to accept this Resolution, the following wording as submitted in the original Resolution would be acceptable to accomplish this change. This wording is submitted below.

SECTION 4. ASSOCIATE MEMBERS. A physician may be granted Associate Membership if he *is engaged in State or County Medical services or if he is a full-time salaried member of an approved medical faculty in this state or who* is an intern or resident in a hospital whose internship program is approved by the State Board of Medical Examiners **and to other physicians who are recommended by their county medical societies and approved by the Executive Committee of MAG.** An Associate Member need not be licensed to practice medicine in the State of Georgia. Associate Membership, except as otherwise provided herein, also may be granted to a member of a component medical society. Associate Members shall pay no dues and shall not be entitled to vote or hold office, nor shall they be entitled to receive any publication of the Association except by personal subscription.

REFERENCE COMMITTEE RECOMMENDATION:

Your Reference Committee discussed this recommendation at great length. Your Reference Committee unanimously advises approval of the recommendations of the Constitution and Bylaws Committee for the reasons succinctly stated in Committee Report 10.

HOUSE OF DELEGATES ACTION—Voted to not adopt the recommendation of the Committee on Constitution and Bylaws, and, in effect, voted to amend the Bylaws as per the suggested language provided by the Constitution and Bylaws Committee.

RESOLUTION 10
CONSTITUTION AND BYLAWS

M. A. Glucksman, M.D.

WHEREAS, Chapter XV of the Bylaws of the Association requires that all proposed amendments to these Bylaws must be submitted to the Association's Committee on Constitution and Bylaws at least *75* days prior to the Annual Session unless an emergency is declared by a two-thirds vote of the Board of Directors; and

WHEREAS, in practice this requirement results in a minimum lapse of a year between proposal and enactment of an amendment to the Bylaws; and

WHEREAS, it is not at all clear that such a delay is contemplated in the language of the first paragraph of said Chapter XV; and

WHEREAS, the present language of the said Chapter XV might be interpreted to require that, if the House or a Reference Committee were to change the wording of an amendment recommended to it by the said Committee on Constitution and Bylaws, still another year must pass before definitive action thereon by this House;

NOW, THEREFORE, BE IT RESOLVED, that the Committee on Constitution and Bylaws of the Association be directed to prepare an appropriate amendment to the Bylaws of the Association, for presentation to the House of Delegates in 1979, DELETING the *second* sentence of the *second* paragraph of said Chapter XV; and be it further

RESOLVED, that the said Committee be directed to prepare an appropriate amendment DELETING the *final* sentence of Chapter X, Section 6.

REFERENCE COMMITTEE RECOMMENDATION:

This resolution was submitted by Dr. M. A. Glucksman. This resolution suggests that current procedures which require proposed amendments to the Bylaws be submitted to the Committee on Constitution and Bylaws at least 75 days prior to the Annual Session poses an undue barrier to the convenience and orderly consideration of such amendments. The resolution further proposes to remedy this situation by eliminating the 75-day requirement. Dr. Glucksman cited examples to indicate that this requirement often in actual practice results in delays of 1 year for amendment of the Bylaws, whereas other language indicates that changes in the Bylaws are expected to be accomplished in a briefer fashion. Current and former members of the Committee on Constitution and Bylaws shared with the Committee the following objections to eliminating the 75 day requirement.

1. Proposed amendments often require the Constitution and Bylaws Committee to review carefully many, if not all, of the various provisions now contained in our Constitution and Bylaws to be certain that no conflicts exist.

2. Convening a properly attended Committee meeting often requires a delay of approximately two weeks.

3. Proposed amendments may frequently require an opinion from our legal counsel, who must also have ample time to review pertinent statutes. Former members of the Committee pointed out that the 75 day requirement was instituted originally because of difficulties which arose when amendments were submitted on the eve of an Annual Session. It was further pointed out that submission of such proposals 30 days in advance had been attempted, only to find that this did not provide a sufficiently flexible time frame. Testimony was heard which suggested that under the present language, it is more difficult to amend the Bylaws than to amend the Constitution. In the opinion of your Reference Committee, that opinion is not correct. It was further the opinion of your Reference Committee that the difficulties created by a 75 day waiting period could in large measure be overcome by a more persistent educational effort, which would acquaint all interested parties with the necessary procedure. In the final analysis, your Committee was unanimous in their belief that a mechanism which delays hasty action with reference to changes in the Bylaws and/or the Constitution is in the best interest of orderly and consistent function on the part of the Medical Association of Georgia.

Mr. Speaker, for these reasons, your Reference Committee advises against the adoption of Resolution 10.

HOUSE OF DELEGATES ACTION—Voted to not adopt Resolution 10.

RESOLUTION 11
CONSTITUTION AND BYLAWS

M. A. Glucksman, M.D.

WHEREAS, Chapter VIII, Section 2, of the Bylaws of the Association reads in part "Membership must be maintained in the Association and in the component society," and

WHEREAS, this provision is apparently inconsistent with that portion of Chapter X, Section 4, which reads "Any disciplinary action of a member by the Board of Directors shall only affect a member's standing in the Medical Association of Georgia . . . but such member's standing in his component medical society shall not be affected thereby . . . ,

NOW, THEREFORE, BE IT RESOLVED, that the Committee on Constitution and Bylaws of the Association be directed by this House to prepare an appropriate amendment to the aforesaid Chapter X, Section 4, so as to dissolve the inconsistency and reaffirm the Association's commitment to the principle of unified membership.

REFERENCE COMMITTEE ON C & B

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 11 was submitted by Dr. Glucksman. This Resolution calls attention to an apparent inconsistency between Chapter VIII, Section 2 of the Bylaws of the Association and the last portion of Chapter X, Section 4. Under our current unified membership, an individual is a member of the component society, and the Medical Association of Georgia or he is a member of neither. Chapter 10, Section 4 reads in part, "Any disciplinary action of a member by the Board of Directors shall only affect a member's standing in the Medical Association of Georgia . . . but such member's standing in his component medical society shall not be affected thereby. . . ." Initially, your Reference Committee was inclined to agree with Dr. Glucksman that this indeed constituted an inconsistency. However, the remainder of Chapter X, Section 4 reads as follows: "a written report of such disciplinary action shall be made to the secretary of the component medical society of which the disciplined member is a member, but such member's standing in his component county medical society shall not be affected thereby, but only pursuant to the action of the component county medical society according to its Constitution and Bylaws." For the benefit of the Delegates, this language appears near the bottom of page 19 of the Constitution and Bylaws. It is the opinion of your Reference Committee that component county societies have altered their Constitution and Bylaws to conform to the Constitution and Bylaws of the Medical Association of Georgia, which includes the principle of unified membership. It therefore follows that the local society would, under its own Constitution and Bylaws no longer extend membership to an individual who, for whatever reason, was not a member of the Medical Association of Georgia. Conversely, an individual, who, for whatever reason, is no longer a member of his component society would, in accordance with the Constitution and Bylaws of the Medical Association of Georgia no longer belong to the State Organization. Your Committee studied in detail Section 4 in its entirety, which begins near the bottom of page 17 of the Constitution and Bylaws and continues to the bottom of page 19.

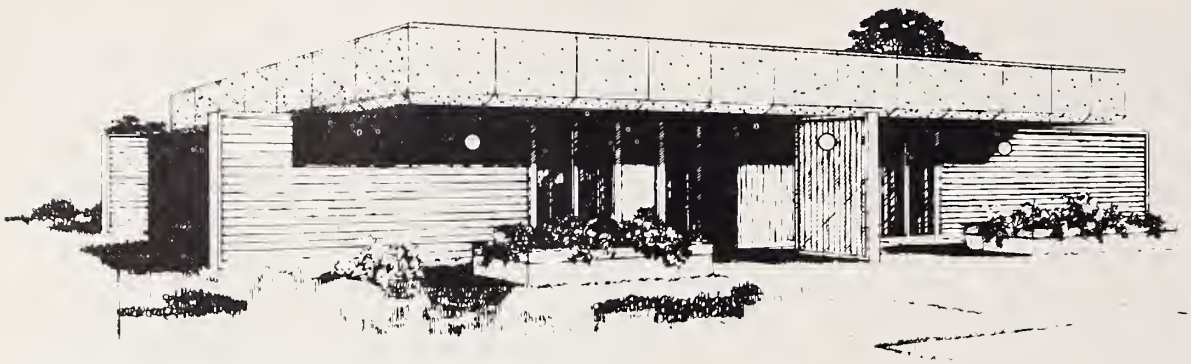
This contains the various conditions and circumstance under which the Board of Directors and/or the Medical Association of Georgia Committee on Professional Conduct would even consider disciplinary action. This examination compels the members of your Reference Committee to the conclusion that under any imaginable set of circumstances, both the component medical society and the Medical Association of Georgia would be bound by identical constitutional and/or bylaw requirements. It is true that the present language does ultimately require action by two bodies. It was the opinion of your Reference Committee that under today's concern with due process, this duality of function is an asset rather than a liability. Our legal counsel, Mr. Vincent was consulted, both regarding the Resolution as submitted by Dr. Glucksman, and with regard to the arguments outlined above. Mr. Vincent agrees that there was an apparent inconsistency, but it was also his opinion that consideration of the entire language contained in the last paragraph of Chapter X, Section 4, would, in its entirety, eliminate the apparent inconsistency.

Mr. Speaker, for the reasons stated above, your Reference Committee would advise the House of Delegates not to adopt Resolution 11.

HOUSE OF DELEGATES ACTION—Voted to not adopt Resolution 11.

Chairman Raines expressed his appreciation to the members of the Reference Committee and thanked all those who appeared before the Committee to express their views and to staff for their help in the preparation of this report.

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Members of Reference Committee A (left to right) F. William Dowda, S. W. Clark Jr. (chairman), LaMar S. McGinnis Jr. (vice chairman), joined by Chairman of the Board Joe C. Stubbs.

Report of Reference Committee A

S. W. CLARK JR., M.D., Chairman
LAMAR S. MCGINNIS JR., M.D., Vice-Chairman

Chairman Clark reported to the House of Delegates that the reports and resolutions referred to Reference Committee A, which met in Colony Hall, Holiday Inn, Jekyll Island, Georgia, on April 14, 1978, were carefully considered. The members of the Reference Committee present were: S. W. Clark Jr., M.D., Chairman, Waycross; LaMar S. McGinnis Jr., M.D., Vice-Chairman, Decatur; Joseph T. Christmas, M.D., Vienna; D. Hubert Manning, M.D., Brunswick; William D. Logan Jr., M.D., Atlanta; and Charles J. Rey Jr., M.D., Austell.

AD HOC COMMITTEE ON STATE BOARD OF MEDICAL EXAMINERS

Charles E. Harrison Jr., M.D., Chairman

Following the appointment of this Committee in January 1977, the Committee has had six formal meetings. During one of these meetings, we heard from a member of the Maryland Commission on Medical Discipline. During two of our meetings, we met jointly with several members of the Georgia State Composite Board of Medical Examiners. On another occasion, as chairman of this Committee, I made a presentation regarding reorganization to the entire membership of the Composite State Board of Medical Examiners during one of their meetings.

It is a great pleasure to inform you that the acceptance of this Committee by the membership of the Composite State Board of Medical Examiners has been overwhelming. I can truthfully state that the rapport between these two groups could not be better. This Committee has learned from the Board numerous problems which the Board faces daily, and likewise, the Board of Medical Examiners has seen, through us, the feelings of numerous physicians throughout the state regarding the effectiveness of the Board.

This Committee, having read and studied the entire Medical Practice Act, the Rules and Regulations governing physicians licensed under the Medical Practice Act, medical practice acts of numerous other states, issues the following report and recommendations. These will be incorporated in a new medical practice act to govern the physicians of Georgia. Hopefully, this can be introduced in the 1979 Georgia General Assembly.

RECOMMENDATIONS

1. The present State Board of Medical Examiners will be doubled to include two divisions: (A) *Licensure*–This division shall deal only with administering examinations for licensure, evaluating candidates for licensure and reciprocity licenses for those groups falling under the current auspices of the Composite State Board which are: physicians assistants, emergency medical technicians, orthotists, orthotists assistants, certified cardiac technologists, advanced medical technicians and physicians (medical doctors and osteopaths). (b) *Division of Quality Assurance*–This division shall be the disciplinary arm of the Board of Medical Examiners.

2. There will be eleven physicians on each arm (10 licensed medical doctors and 1 osteopath) with two lay members on each division. The lay members shall not be in the health care delivery field or the ancillary health field. The ten M.D. physicians (one from each congressional district in Georgia) shall be appointed by the Governor from a list submitted by the Medical Association of Georgia. The one osteopath physician shall be appointed by the Governor from a list submitted by the Georgia Osteopathic Association. The lay members shall be appointed by the Governor using his best discretion.

This committee acknowledges that a suit is currently pending against the Board of Medical Examiners and MAG challenging the constitutionality of the appointment process in which the Governor is mandated to appoint the M.D. physicians to the current Board from the list submitted by MAG.

3. The licensure division of the State Board of Medical Examiners will deal with licensure and the supervision of qualifying examinations from all those groups which fall under the auspices of the Board. The division of Quality Assurance may probate, suspend, revoke and censure a license. Once action has been taken against an individual for his license, all future action on this individual's license will fall under the prerogative of the Division of Quality Assurance which originally acted upon the individual's license.

4. The investigatory schema of the State Board of Medical Examiners would involve peer review by professionally qualified persons from the various professional disciplines over which the Board has control. This peer mechanism will be up to the discretion of the Division of Quality Assurance. Their options would be—(under current law): (A) The component county medical society (B) MAG peer review system or (C) 1. The present investigative set-up under the Secretary of State's office and 2. The Division of Quality Assurance may handle it itself.

5. Depending upon which option is used in peer review investigation, reports are to be made to the Division of Quality Assurance within 90 days unless an extension is granted. The Division of Quality Assurance should be able to grant subpoena power and supply legal counsel from the Attorney General's office to any investigative body listed above.

6. It should be clearly stated that blanket immunity is given to the complainant, everyone through the peer review mechanism and the members of the State Board of Medical Examiners.

7. Regardless of where deliberations may be in the judicial process, the Division of Quality Assurance should be able to take action on an individual's license should they deem this appropriate.

8. We further recommend that this committee be continued and be authorized to work with the Legislative Committee, the MAG attorney, and appropriate state legislators and the executive branch of government until the implementation of the proposals are Georgia law or until abolished by the appropriate body of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION:

The Ad Hoc Committee on State Board of Medical Examiners asks that the present State Board of Medical Examiners be doubled to include two divisions. One would be concerned with licensure and the other would be the disciplinary arm. There would be 13 positions in each division (ten licensed medical doctors and one osteopath) with two lay members in each division.

It is evident to Reference Committee A, that from the information brought before it, there is a strong need in Georgia for increased attention to medical discipline. Your Reference Committee also wishes to point out that this was recognized as early as 1962, when the then Council of MAG recommended establishing a Board of Medical Discipline.

Mr. Speaker, your Reference Committee advises adoption of Recommendations 1 through 8. We further advise that the House of Delegates not engage in unnecessary debate on particular wording of a proposed bill, but rather leave this to the coordination of efforts as emphasized in recommendation 8 to effectuate a properly worded legislative proposal which will accomplish the intent of these recommendations.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Ad Hoc Committee on State Board of Medical Examiners.

SPEAKER OF THE HOUSE

L. C. Buchanan, M.D., Speaker

By custom, an MAG officer's report is usually one largely of accountability with occasional recommendations for change.

Last year in announcing my intent to seek a second term as Speaker, I pledged my efforts to three main objectives:

(1) Work for absolute integrity in all areas of MAG activity.

(2) Attempt to progressively eliminate our VOLUNTARY involvement with governmental and other third party projects and programs, and to reaffirm as being our primary goal the patient's interests.

(3) Seek to improve and strengthen MAG through increased organizational efficiency.

During the past year your Speaker has attended all meetings of the Board of Directors and all meetings of the Executive Committee, except those convened out of state, and constantly attempted to be certain that the actions of both bodies were in accord with previous directives of the House of Delegates. In addition I have endeavored to consistently uphold the three objectives cited above to the Board of Directors, the Executive Committee, and staff. In all candor, I must report little progress during the year in multiple areas and much remaining to be accomplished.

The MAG is no longer to administer CHAMPUS. The Georgia Medical Care Foundation, now physically housed in headquarters building, will doubtless have a different level of activity as we move to establish and activate PSRO for Georgia as directed by the House. Increasing HSA activity statewide, directly affecting medical practice; third party insistence on utilization review for fiscal purposes; demands for our participation in medical care cost containment; increasing numbers of professional liability litigations against physicians; are but a few of the items which today challenge the MAG and demand a more unified, efficient, and effective organizational activity on a day-to-day basis. We slowly gain in numbers of dues paying members but desperately need more individual members willing to give time and effort with personal involvement at all levels if we are to present as the strong, effective and productive organization, dedicated to quality patient care, which is our capability.

The Annual Session Committee has been increased from two to four members and now consists of the president, the president elect, the vice speaker and the speaker and this Committee will seek to review resolutions and recommendations received after the deadline of April 14, after the House convenes, as announced in the January 1978 MAG *Newsletter* and by letters of December 15 and January 13 to all Delegates, Alternates, and County

Societies. This has been done in an attempt to expedite the lengthy Annual Session agenda.

This year, for the first time, the House of Delegates will convene on Friday, Saturday and Sunday, in three sessions instead of only twice as in former years, again as a trial maneuver intended to shorten the long final session on Sunday.

The proceedings of our Annual Session have been impeded to some extent, and frequently have presented somewhat awkward situations, by the presence of many persons not members of MAG, non physicians, administrative officers of the bureaucracies, paramedical people, etc. This was particularly a problem in 1977 and a number of delegates have complained that they felt restricted in their ability to discuss matters because of the presence of such persons. In the past, a number of people in these categories have been formally invited by the MAG to attend the Annual Session. This practice has been the subject of much discussion and the Speaker submits the following recommendations for House deliberation:

(1) WHEREAS, the Medical Association of Georgia depends on the House of Delegates to formulate its policy and strategy for conduct of its affairs; and,

(2) WHEREAS, the amount of time available for discussion and debate at the Annual Session is restricted; and,

(3) WHEREAS, the reference committee structure has been determined as the mechanism for the study and evaluation of various issues at the Annual Session; now

(4) THEREFORE BE IT RESOLVED, that the House of Delegates establish a policy regarding not inviting certain guests to attend our Annual Session who are not physicians and/or are not members of the MAG, and, furthermore, that the House of Delegates establish a policy expressing its desire to have reference committees meet in closed door sessions, open only to members of the MAG. Testimony by other than MAG members to be scheduled in advance at the discretion of the Reference Committee.

As our Association grows in size and complexity, and as the problems confronting us increase, it is becoming increasingly difficult to adequately accomplish the mission of the House of Delegates with a single annual meeting. At some time in the future, meetings at a greater frequency will at least have to be considered. For the present, it is the sincerest desire of the Annual Session Committee and of your Speaker in particular, to conduct the business of the House of Delegates in a manner that is efficient, expeditious, devoid of extraneous debate and oratory, and yet based on the principle of fairness to all.

REFERENCE COMMITTEE RECOMMENDATION:

Your Reference Committee read with interest the annual report of the Speaker of the House and appreciates his involvement and concern for Association affairs.

The Speaker asked the House to establish a policy of not inviting certain guests to the Annual Session who are not MAG members and that Reference Committee hearings be open *only* to MAG members.

RECOMMENDATION:

Mr. Speaker, your Reference Committee advises that the recommendations included in Officer report 9 be not adopted, and offers the following substitution:

REFERENCE COMMITTEE A

1. MAG abolish any established precedent of inviting individuals representing certain groups.

2. Invitations to the Annual House of Delegates should be left to the discretion of the Annual Session Committee.

3. Appearances before any Reference Committee by other than MAG members will be by approval of the Reference Committee Chairmen.

4. A roster should be kept of individuals in attendance as they file into the Reference Committees and given to the Reference Committee Chairman for his information.

HOUSE OF DELEGATES ACTION—Voted to not adopt the report of the Speaker, and to adopt in lieu thereof, the substitute recommendation made by the Reference Committee.

COMMITTEE ON PRISON HEALTH CARE

J. Rhodes Haverty, M.D., Chairman

This Committee's function continues to be providing guidance and input to MAG's Program to Improve Health Care in Jails, a subcontract from the AMA, which is entering its third year.

During the project's second year the AMA Standards for health care programs were finalized and the first two rounds of accreditation surveys and awards completed. Committee members individually participated in the accreditation process and the committee functioned as the review and recommendation of the body to the AMA National Advisory Board. The accreditation program has become ongoing and its expansion in the third project year will require the committee's continued active involvement.

The Committee planned and sponsored a workshop on Receiving Health Screening for Jail Personnel, which was presented twice during the year to jail staff representing the original pilot jails and other jails joining the project. An orientation workshop for physicians interested in providing health care in jails was also designed and produced by the committee.

The achievements of the program thus far are a proud indication of this committee's sincere commitment to the program's goals. As the project enters its third and final year of external funding the MAG must address itself to future continuation of this activity. The committee firmly believes that it is important for the MAG to be actively involved in health care in jails, and furthermore that it should be a priority item for the MAG. The committee feels that this activity should be undertaken as an obligation to the community to improve health care in a long-neglected and traditionally apathetic area of public concern. It is imperative that the MAG, representing the medical profession, assume this responsibility both financially and personally.

RECOMMENDATION

The MAG continue to assume the responsibility of

improving health care in jails by supporting the current program during reduced funding and after cessation of AMA grant funds.

REFERENCE COMMITTEE RECOMMENDATION:

The Committee on Prison Health Care reports the MAG Program to Improve Health Care in Jails is entering its third year under a subcontract from AMA. Funding for the project from AMA has been reduced for 1978 and will stop completely in March 1979. The Committee asks that MAG continue to support the program after AMA grant funds cease.

Mr. Speaker, your Reference Committee advises that MAG continue supplemental funding for the fiscal year 1978. We would emphasize the value and importance of the Program and advise that, beginning fiscal '79, funding be continued for the Program to Improve Health Care in Jails from sources other than MAG.

HOUSE OF DELEGATES ACTION—Adopted in lieu of the recommendation by the Reference Committee, the floor's substitute as follows:

Mr. Speaker, your Reference Committee advises that MAG continue supplemental funding through March 6, 1979. We would emphasize the value and importance of the program, and advise that beginning March 7, 1979, funding be continued for the Program to Improve Health Care in Jails from sources other than MAG.

RESOLUTION 19
PROPOSED CHANGES IN CODE OF ETHICS
MEDICAL ASSOCIATION OF ATLANTA

WHEREAS, the AMA Judicial Council introduced proposed changes in the Code of Ethics in December 1977, and asked for views and suggestions, and

WHEREAS, the proposed changes as published in the *AM News* reflect a change in thrust from the individual toward the collective, and

WHEREAS, the proposed changes remove the prohibition of solicitation of patients (Sec. V), and

WHEREAS, the proposed changes modify Sec. VI of the Code of Ethics so as to allow physicians to enter into contractual obligations that could influence their medical judgement or could cause a deterioration in the quality of care, and

WHEREAS, the proposed changes allow for physicians to obtain professional income from sources other than medical services rendered by that physician (Sec. VII), and

WHEREAS, the proposed changes add the burden of "social responsibility" to the physician (Sec. X), and

WHEREAS, these combined proposed changes will effectively lower the ethical standards of physicians by changing the intent of the current standards, and

WHEREAS, public opinion polls have reported that physicians are consistently at the highest levels of esteem and confidence of the public, and

WHEREAS, this level of professionalism has been accomplished with our current Code of Ethics as standards of conduct,

NOW, THEREFORE, BE IT RESOLVED, that MAG House of Delegates reaffirms its position adopted in 1977, specifically "tightening ethical standards of its members so as to impress upon the public its ability and desire to maintain the highest ethics of the practice of medicine" (Resolution 33-77), and BE IT FURTHER

RESOLVED, that the MAG House of Delegates finds the proposed changes submitted by the Judicial Council of the AMA to be unacceptable, and BE IT FURTHER

RESOLVED, that the MAG instruct its AMA delegation to introduce a resolution opposing the proposed changes, and to further oppose any changes that would lower the highest ethical standards of the medical profession.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 19 asks that the proposed changes in the Code of Ethics offered in December 1977 by the AMA Judicial Council be opposed by MAG and that the AMA Delegation be instructed to introduce a Resolution opposing the proposed changes and to further oppose any changes that would lower the highest ethical standards of the medical profession.

Mr. Speaker, your Reference Committee advises that Resolution 19 be not adopted, but that the AMA Delegation be given the discretion to make what changes are needed to comply with the FTC regulations while continuing to comply with the highest ethical standards of the medical profession.

HOUSE OF DELEGATES ACTION—Adopted Resolution 19 as introduced.

RESOLUTION 9
HEALTH SYSTEMS AGENCIES

Muscogee County Medical Society and Glynn County Medical Society

WHEREAS, Health Systems Agencies have been established in several areas of this State under appropriate Federal laws and regulations; and

WHEREAS, the said Health Systems Agencies have the power to exert a tremendous degree of control over the conditions under which Medicine is practiced in this State, both now and, perhaps increasingly, in the future; and

WHEREAS, the federal laws and regulations under which said Agencies are organized and operated stringently limit the representation of physicians on the Governing Bodies of said Agencies and on the important operating Committees of said Agencies, with the result that it is at present very difficult for physicians to keep abreast of the proposed actions of such Agencies and to make timely and meaningful representations to said Agencies in an effort to influence their decisions; and

WHEREAS, the geographical areas served by the several Health Systems Agencies in Georgia are *NOT* congruent with those of the several District Medical Societies; now THEREFORE BE IT

RESOLVED, that there be established a PHYSICIANS' TASK FORCE in each of the Areas of Georgia having a Health Systems Agency; and BE IT FURTHER

RESOLVED, that the Board of Directors of the Association be directed to appoint to each such TASK FORCE 1) those members of the Association who are members of the Governing Body of the Health Systems Agency in its

geographical Area and 2) other interested, concerned, and articulate members of the Association so as to give reasonable representation on the Task Force to the several County Medical Societies in the HSA's Area; and BE IT FURTHER

RESOLVED, that the Board of Directors of the Association be encouraged to provide, from its contingency funds, necessary and appropriate financial support for the activities of the several Task Forces during their first year of operation and to make appropriate budgetary provisions for the activities of the several Task Forces in subsequent years.

RESOLUTION 25

HEALTH SYSTEM AGENCIES

Cobb County Medical Society

WHEREAS, investigation of the North Central Georgia Health Systems Agency, Inc. by a group of Cobb County physicians, both voluntary and appointed, has led to great concern regarding the activities of this agency, and

WHEREAS, data that was reviewed consisted of a review of the North Central Georgia Health Systems plan for the years 1978 to 1982 which included the executive summary, the plan itself, the appendices and the annual implementation plan, and

WHEREAS, the composition of the agency and more specifically the composition of board members as it relates to the physician-provider; and a previous budget, and

WHEREAS, the first objection concerns the information provided by the North Central Georgia Health Systems plan, and

WHEREAS, it is felt that many of the plans have unrealistic goals, have already been tried and failed, or are currently being applied through other agencies both in the private and public sectors, and

WHEREAS, erroneous data has also been found within the health systems plan, and

WHEREAS, of the sixty-nine members of the board of the North Central Georgia Systems Agency, Inc., only nine are physicians, and

WHEREAS, more importantly, physicians are selected through the Health Systems Agency nominations and do not necessarily represent representation from the bulk of the physician-provider sector who practice medicine throughout the State of Georgia, and

WHEREAS, it is felt that widespread "grass roots" representation providing physician input into this agency is urgently needed, and

WHEREAS, a review of a previous budget revealed that $448,137.65 was expended and most of this provided salaries and fringe benefits to the staff members, and

WHEREAS, legal fees seemed rather high as did fringe benefits, and

WHEREAS, public notices to apprise consumers and health care providers seemed peculiarly low at $445.59, and

WHEREAS, the budget has no provision for the countless millions of health care dollars proposed in the five year plan. NOW, THEREFORE, BE IT

RESOLVED, that the Medical Association of Georgia approves the formation of a health care delivery committee, with representatives from each county medical society and each of the seven health systems districts, and BE IT FURTHER

RESOLVED, that each county medical society elect one representative and one alternate to represent each of the seven health system districts, and BE IT FURTHER

RESOLVED, that a chairman be appointed by the Executive Committee of the Medical Association of Georgia to coordinate the function of this health care delivery committee with existing committees, and BE IT FURTHER

RESOLVED, that the intent and purpose of this Committee is to monitor the activities of the Health Systems Agency and other related agencies in regard to health care delivery in the State of Georgia, and BE IT FURTHER

RESOLVED, that each district member or his designate serve as a provider member of the Health Systems Agency, and that each elected county medical society member or his designate serve as a provider member of the Health Systems Agency, and BE IT FURTHER

RESOLVED, that this Committee provide a mechanism for immediate dissemination of information to, and participation by, the physicians of the state at a local level, and provide greater physician input into the formation of policy and direction of these agencies.

REFERENCE COMMITTEE A

COMMITTEE ON HEALTH PLANNING

J. W. Chambers, M.D., Chairman

Since the last annual session of the Medical Association of Georgia, this committee has continued to be involved in increasing amounts of activity. This has been necessitated by the increasing activities of the various HSA organizations in the State of Georgia as they become better organized and more involved in activities and also by Federal activity from the Department of HEW as their activities relate to the guidelines and regulations of the HSA activities.

We have attempted to keep the Executive Committee and the Board of Directors apprised of activities and of elements as they have occurred during the year. Specifically, all 7 HSA's in Georgia are now well organized, all have developed their annual implementation plan, and insofar as I know, all of them have applied for their permanent designations as HSA's. I am not apprised as of this writing as to whether or not or how many have received approval for permanent status. I believe this House would like to know that the Executive Directors of the HSA's have been cooperative with this committee and have provided it with volumes of information from time to time which your Chairman has attempted to monitor and pass on to the committee where appropriate. During the period shortly after our last annual meeting, the State Health Planning and Development Agency was developed and established by the Governor and is now functioning. For the information of the House and its members who perhaps might not be aware, the structure of the Health Planning and Development Agency is as follows:

To be independent of the Department of Human Resources and will report directly to the Governor. The

commission members are Mr. David Poythress, Director of Medicaid, Dr. Doug Skelton, Director of the Department of Human Resources, L. Howard Atherton, Director of the Bureau of Community Affairs, Dr. Harry O'Rear, Vice Chancellor for Health Affairs of the Board of Regents and Mr. Johnny Caldwell, Comptroller General and Insurance Commissioner. To my knowledge the appointment of the statewide health coordinating council has not been made by the Governor as of this time.

September 23, 1977, the Secretary of HEW published in the Federal Register the proposed actual guidelines for health planning with a response date imposed of November 21, 1977. These proposed guidelines in fact were proposed as actual rules and regulations governing the operations of the HSA's in all phases from hospital beds, occupancy rates, service facilities of various types which were all couched in extremely difficult Federal language. With the help of the Executive Committee and staff, primarily your Chairman with some help from some members of the committee since a committee meeting could not be effectively organized during that time, proper responses to these proposed guidelines were drawn and then this information was then condensed and turned over to the President of MAG to respond to these guidelines and this was done on schedule prior to November 21, 1977. Index as to the controversy of these guidelines might be noted at this time since the Department of Health, Education and Welfare received some 55,000 responses to the guidelines in the 60 day period allowed. On January 20, as the result of the many responses, additional revised guidelines were proposed and published and a 30 day response period was allowed. Again, with the help of the Executive Committee and staff, the necessary responses were drawn and reviewed and submitted to the President of MAG for his response to these guidelines which was done effectively by February 21, 1978.

I am encouraged to report that we have received numerous responses from our Congressional delegation in regards to the response of the MAG to the proposed guidelines. Many of these responses have been extremely helpful to this committee and I am sure to our Board of Directors and Executive Committee.

During the two years in which I have had the privilege and pleasure of serving as Chairman of this Committee, it has become increasingly apparent that the work load of this Committee will continue to grow, or at least it should continue to grow, with the development of the activities in the health field, both from the Federal government and from the local areas. Up until this time this Committee has been composed of seven members who are physician members of HSA boards, there being seven HSA's in Georgia: three at-large members and a Chairman, making a total of eleven members. I do not believe that an eleven man committee can continue to carry the loads, to which this committee will be subjected and effectively carry if it does an adequate job for this great medical organization. In January, 1978, at the Board of Directors meeting, this problem was brought before the Board of Directors and was discussed at considerable length and, hopefully, from some recommendations that may come from the Board of Directors, this Committee can be expanded, particularly more so on the local level so that greater participation and greater information can be dispensed to our membership as it relates to the activities that this Committee has been charged to carry. It would be the recommendation of the Chairman that this be accomplished as was proposed in whatever specifics that might be developed and also it seems appropriate at this time that the Chairmanship of this Committee be shifted to a younger and perhaps more aggressive physician since the activities are inevitably to be greater and should be more effectively carried out.

It has been my privilege and pleasure to serve as your chairman this year and I shall be happy to try to provide any members of the House any additional information they might like to have.

Finally, I would like to express my great appreciation to Rusty Kidd and Billie Griffin for their tremendous assistance in the performance of our duties during this year. Without their help and the help of other members of the staff, our job could not have been done.

RESOLUTION 26
FULL-TIME HEALTH PLANNER

Cobb County Medical Society

WHEREAS, the trend of increasing control, regulation and involvement of federal and state agencies in health care is readily apparent, and

WHEREAS, an unfortunate by-product of this problem is the massive amount of written material in the form of guidelines, regulations, plans, statistics and other facts which may or may not be accurately represented, and

WHEREAS, the Medical Association of Georgia very actively and effectively deals with the state legislative aspects of health care programs, and

WHEREAS, it is apparent that review of material from federal agencies and state agencies that are not involved with the legislative process have not been carefully monitored, and

WHEREAS, it is of upmost importance that the Medical Association of Georgia understand all communications regarding health care as quickly and accurately as possible.

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia hire a full-time health planner to review and interpret new and existing programs for delivery of health care in the State of Georgia, and

BE IT FURTHER RESOLVED, that this planner report such data to all appropriate Medical Association of Georgia committees.

REFERENCE COMMITTEE RECOMMENDATION:

Mr. Speaker, Resolutions 9 and 25 both deal with HSAs and were considered at the same time along with the report of the Committee on Health Planning. Resolution 26 would provide for an MAG full-time health planner. As these four items of business were so interrelated, testimony was heard in concert on all four items.

Briefly, Resolution 9 asked that the MAG Board of Directors appoint a task force of physicians and others to work with and monitor the HSAs.

Resolution 25 asks that a Health Care delivery committee be established to monitor the HSAs.

Committee Report 18, the Committee on Health Planning, asks that the current committee be expanded.

Resolution 26 would provide that MAG employ a

staff person to deal exclusively with reviewing and interpreting new and existing programs for delivery of health care in the State of Georgia.

Mr. Speaker, your Reference Committee, after hearing lengthy testimony on what mechanism would best serve MAG's interest in the area of health planning and HSAs, advises that Resolutions 9, 25, and 26 be not adopted. Your Reference Committee wishes to substitute the following recommendation: That an Ad Hoc Committee be established by the MAG Executive Committee with the purpose of increasing physician input into the Health Systems Agencies and health planning in general, and that the Committee bring its recommendations for resolving the current situation to the MAG Board of Directors. Mr. Speaker, your Reference Committee feels that contents of Resolutions 9, 25 and 26 are of such import that no satisfactory solution could be found in the two days of deliberation of the House of Delegates. Your Reference Committee recommends that Committee Report 18 be accepted for information with commendation.

HOUSE OF DELEGATES ACTION—Delegate Philip Israel withdrew Resolutions 25 and 26, introduced by the Cobb Delegation. This was accepted by the Chair. Delegate F. William Dowda moved to amend by deletion of the entire Reference Committee recommendation, and to substitute in lieu thereof, the three RESOLVES of Resolution 9 plus the last sentence of the Reference Committee recommendation, which reads, "Your Reference Committee recommends that Committee Report 18 be accepted for information with commendation."

AMA DELEGATION

Harrison L. Rogers Jr., M.D.

In 1977 the American Medical Association Delegation continued the interval reports to the Medical Association of Georgia membership which were initiated following the Winter Meeting in Philadelphia (December, 1976). After each of the AMA meetings (June and December) the delegation has prepared a summary of the activity of both the Georgia Delegation and the final actions of the House of Delegates. These reports serve to keep our members abreast of AMA developments and have been well received. If the House approves this procedure, we will continue to produce these reports shortly after each AMA meeting. This format would then include an abbreviated "Annual Report" to the Georgia House of Delegates. Additional copies of the interval reports will be available for the Reference Committee.

One of the highlights of 1977 was the successful campaign by MAG in nominating and electing Harrison Rogers as Vice Speaker of the AMA House of Delegates. Georgia physicians, their wives and MAG Staff started early in 1977 building a foundation of personal contacts with letters and phone calls. A charter plane took a record number of Georgians to the June meeting in San Francisco where they turned in an outstanding performance resulting in a successful election.

As Vice Speaker, Dr. Rogers participates in the planning and operation of the House of Delegates and, in addition, serves on the Board of Trustees of the AMA. His position there is ex officio without a vote but with the privilege of debate. He also serves as an ex officio member of the Council on Constitution and Bylaws. As your representative on the AMA Board, Dr. Rogers has urged that MAG make full use of his election to advocate the position of MAG on any issue. The AMA Board meets at monthly or bimonthly intervals.

The Winter meeting was held in Chicago in December with temperatures near zero throughout the meeting. Our state was again represented well with excellent coverage of reference committees as well as during debate on the floor of the House. Probably the most important issue faced was direct specialty society representation in the House of Delegates and this was approved. In the past, specialty organizations have been represented by "Sections" with one delegate per "Specialty Section." With adoption of this new position, most large national specialty societies will elect their own delegate and alternate delegate to the AMA House. Currently 48 national specialty organizations will be eligible to apply for direct representation and this number may increase significantly in the future. Impetus for this change came as a result of efforts to increase participation in and through the AMA rather than via smaller organizations (specialty societies).

RECOMMENDATION

1. That the AMA Delegation continue its policy of preparing a report summarizing AMA House of Delegates actions following each of the meetings and that this report be provided the MAG membership as promptly as possible after the meeting.
2. That MAG staff be directed to encourage our members to attend AMA meetings by providing charter travel arrangements where feasible.

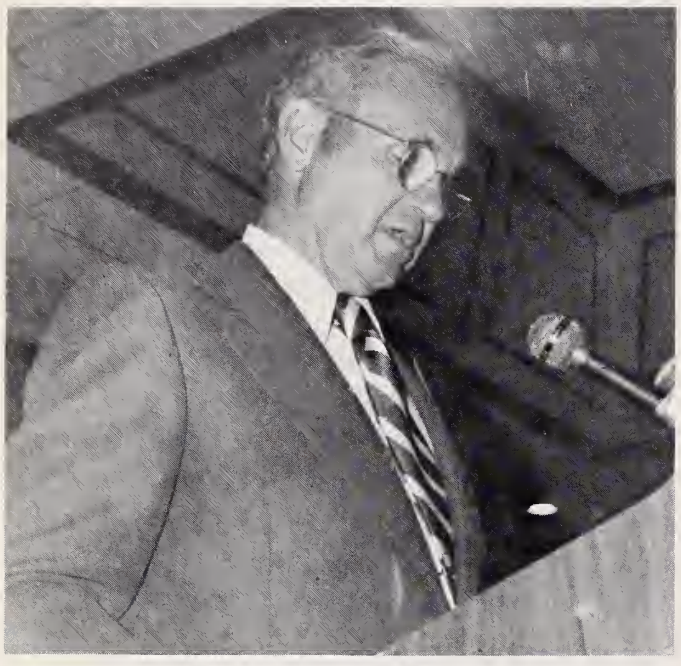
REFERENCE COMMITTEE RECOMMENDATION:

The report of the AMA Delegation asks that the AMA Delegation prepare a report to the MAG membership following the AMA House of Delegates meeting and that MAG staff encourage members to attend AMA meetings by providing charter arrangements where feasible.

Mr. Speaker, your Reference Committee commends the AMA Delegation on its service to MAG and congratulates Dr. Harrison Rogers on his election as Vice Speaker of the AMA House of Delegates. Your Reference Committee advises that recommendation 1 of the AMA Delegation be adopted, and that Recommendation 2 be altered to read, "that MAG be directed to encourage our members to attend AMA meetings by arranging charter travel where feasible." The Reference Committee advises that highlights of the AMA report be printed in the MAG *Newsletter* in lieu of a separate report.

HOUSE OF DELEGATES ACTION—Delegate Duane Blair moved to amend the Reference Committee recommendation by the addition of the following: "The AMA Delegation be directed to present a comprehensive report to the Board of Directors following each meeting of the AMA House of Delegates, consisting of our Delegation's activities and voting record.

This information should be disseminated in summary form, to the entire membership in a subsequent issue of the MAG *Newsletter.*" There was a verbal agreement on the floor between Delegate Harrison L. Rogers and Delegate H. Duane Blair as to the meaning of the preceding amendment. The Blair amendment was



Chairman S. W. Clark presents the Reference Committee's report.

interpreted by the Chair to embody the essence of the observation made by Delegate Harrison Rogers, which was that the AMA Delegation could report in summary form on how the Delegation supported or opposed a particular issue, but that a record of each vote taken would be quite difficult.

The House then voted to adopt Recommendation 1 of the Report of the AMA Delegation; adopted Recommendation 2 as amended by the Reference Committee; and adopted the Blair amendment as interpreted on the floor of the House.

COMMITTEE ON JOINT HOSPITAL SURVEY PROJECT

John M. McCoy, M.D., Chairman

This Committee was established in 1976 with the charge of studying the feasibility of consolidating surveys currently conducted in Georgia hospitals. In 1977 the committee determined that consolidation of surveys was not practicable for the present; in lieu of this it proposed the organization of a program to be called the Joint Georgia Hospital Survey Project, co-sponsored by the MAG, the JCAH, and the Georgia Hospital Association. The program would train 25 to 50 Georgia physicians who would accompany JCAH survey teams for the purposes of serving as liaison between the hospital medical staff and the visiting JCAH surveyors and of evaluating patient care evaluation (medical audit) and continuing medical education activities as well as the organization, delivery, and documentation of medical care in the hospital. Although the 1977 MAG House of Delegates voted to endorse the concept of the program, it did not vote the funds to implement it.

The Committee met in 1978 and addressed itself to the question of how the MAG can best help hospital medical staffs reach the high JCAH standards of medical staff responsibility for quality of patient care. The committee felt that metro area hospitals were not generally in need of such services, but it could not assess the need at hospitals in smaller towns. To determine whether MAG could sponsor a worthwhile service along the lines of the proposed Joint Georgia Hospital Survey Project, a pilot program would have to be conducted at a minimum cost of $20,000. The money would pay for 50 days of physician time to accompany the JCAH survey teams, traveling expenses, a JCAH orientation workshop, and MAG staff time. The committee felt it would take the experience and feedback of about ten physicians, each participating in two or three hospital surveys, to determine the worth of the program. It is the committee's opinion that the cost to determine the feasibility of the program is unjustified. Furthermore, we believe it would be difficult to recruit a sufficient number of actively practicing physicians with a high level of interest in patient care evaluation who would have the time necessary to devote to the project.

Medical staff responsibility for continuing medical education activities within Georgia hospitals is already being addressed adequately through services provided by the MAG Division of Education and Subcommittee on Accreditation. The MAG should let it be known, however, that it is vitally concerned with the quality of patient care in our hospitals and that it stands ready to assist medical staffs in maintaining and improving this care.

With regard to consolidating the numerous surveys which hospitals are subjected to, the committee believes this is basically a challenge for hospital administrators and therefore more appropriately addressed by the Georgia Hospital Association rather than the MAG.

RECOMMENDATIONS

1. That the MAG not continue the Joint Georgia Hospital Survey Project endorsed in theory by the 1977 House of Delegates, since the cost of this program is not warranted by demonstrated need.
2. That the MAG contact the Georgia Hospital Association about the possibility of assisting hospitals and hospital medical staffs in coordinating various hospital surveys so as to avoid duplication of effort and time.
3. That the Committee on Joint Hospital Survey Project Study be disbanded.

REFERENCE COMMITTEE RECOMMENDATION:

The Committee on Joint Hospital Survey Project was established in 1976 to study the feasibility of consolidating surveys conducted in Georgia hospitals. The Committee believes the Joint Georgia Hospital Survey Project is not warranted by demonstrated need and asks that the project not be continued and that the Committee be disbanded. The Committee further recommends that MAG work with the Georgia Hospital Association to assist hospitals coordinating surveys.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that the recommendations of the Committee on Joint Hospital Survey Project be adopted.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Committee on Joint Hospital Survey Project.


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Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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RESOLUTION 12
RURAL HEALTH CLINICS

Cobb County Medical Society

WHEREAS, the Department of Human Resources is investigating the development of Rural Health Clinics in underserved areas of Georgia, and

WHEREAS, these Rural Health Clinics will be responsible for the total primary care of patients in its area, and

WHEREAS, this proposed form of diagnosis and treatment of acute illness is a departure from the traditional philosophy of the public health area, and is traditionally considered the province of the private practice of medicine, and

WHEREAS, the Cobb County Medical Society feels that the patient served by the Rural Health Clinic deserves the quality of care given to the other citizens of Georgia, NOW THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia develop close liaison with those setting up such Rural Health Clinics, and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia study the care in those areas already being served by the Public Health Department in such clinics as: family planning clinics, mental health clinics, cancer detection clinics, and other public health clinics, in order to assess the quality of care, cost effectiveness of such care, and the continuity of such care. Deviation from accepted standards of care and/or cost are to be reported to the Board of Directors before January 1, 1979, for appropriate action.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 12 asks that MAG develop a close liaison with the Department of Human Resources in setting up Rural Health Clinics and the MAG study the care in those areas served by the public health department clinics, such as family planning clinics, mental health clinics, cancer detection clinics and other public health clinics.

Mr. Speaker, your Reference Committee advises that Resolution 12 be adopted.

HOUSE OF DELEGATES ACTION—Adopted Resolution 12 together with an amendment offered by Delegate F. William Dowda to refer Resolution 12 to the MAG Board of Directors for implementation if fiscally feasible during the fiscal year 1978-79.

In an independent action adopted as a rule of the House that whenever a resolution is presented that requires an expenditure of funds, it must be accompanied by a fiscal note.

LIAISON COMMITTEE TO BOARD OF HUMAN RESOURCES

George F. Green, M.D., Chairman

With the exception of Dr. Edwin Allen Jr., of Milledgeville, Georgia, the Liaison Committee was generally inactive with some of the members never attending and others only rarely.

In view of the fact that the Liaison Committee had no apparent effect on the decisions of the Department of Human Resources as, in my opinion, these decisions give the appearance of having been predetermined.

Also, those members of the medical fraternity have continued to exhibit deep concern and careful consideration where they are allowed in-put as members of the board.

RECOMMENDATION

It is my recommendation that the Liaison Committee to the Board of Human Resources be abolished and not funded.

REFERENCE COMMITTEE RECOMMENDATION:

The Liaison Committee to the Board of Human Resources asks that the Committee be abolished and not funded. It has been suggested that one of the five physician members of the Board of Human Resources be asked to attend the MAG Board of Directors meetings and give a report to the MAG Board as necessary.

Mr. Speaker, your Reference Committee advises the adoption of the report.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Liaison Committee to the Board of Human Resources. Delegate Stephen May then moved to create a Liaison Committee to the Department of Human Resources. This was seconded and passed.

REFERENCE COMMITTEE A

RESOLUTION 21
PRIVATE-PUBLIC HEALTH CARE SYSTEMS

Medical Association of Atlanta

WHEREAS, it is recognized by the Medical Association of Georgia and most thoughtful and conscientious physicians that certain inequities and weaknesses exist in our present private-public health care systems and that these problems should be corrected, NOW THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia shall make every effort to remedy those problems and to cooperate fully with all legitimate private and public organizations who make wise and constructive efforts to improve the delivery of health care to the citizens of our country, and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia recognizes that among these health care facets that require improvement are:

A) The Medicare System.

B) Medicaid which "has become a national scandal."

C) The system of benefits offered by the private health insurance industry.

D) Overutilization of hospital facilities.

E) Maldistribution of physicians and health care facilities.

F) The increasing frequency of professional liability litigation often without just cause.

G) The need for sufficient numbers and proper distribution of family physicians and primary health care providers.

H) Education of the public in preventive health care providers.

I) Increasing the availability of information for the public about the realistic expectations for the prevention and cure of disease.

J) Peer review of professional standards and ethical conduct by the profession itself.

K) Improvement in basic standards of nutrition, environmental pollution, control of occupational hazards, and other similar health related factors, and

BE IT FURTHER RESOLVED, that the Medical Association of Georgia recognizes that most of these problems are regional in nature, do not involve a majority of the population, are in part the product of unwise federal and state health care policies and programs, and that our private medical care system has produced the world's highest standard of medical care for the majority of our citizens. The Association strongly endorses efforts to improve our present health care delivery system and deplores proposals that would abolish private medical care and substitute a compulsory, comprehensive federal program.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 21 recognizes that certain inequities and weaknesses exist in our private health care system and asks the Association to strongly endorse efforts to improve health care delivery systems, but deplores proposals that would abolish private health care and substitute a compulsory, comprehensive federal program.

Mr. Speaker, your Reference Committee advises that Resolution 21 be approved.

HOUSE OF DELEGATES ACTION—Adopted Resolution 21.

MEMBERSHIP COMMITTEE

William C. Collins, M.D., Chairman

The membership of the Medical Association of Georgia continues to increase. For the first time, we surpassed the 4,500 mark. Our active membership (one of 12 membership categories) increased from 3,827 members in 1976-77 to 3,978 this year—an increase of 151. Our AMA membership increased from 3,347 to 3,456—an increase of 109.

1977-78 was the second year of our sliding dues structure for those entering the medical profession and for those reaching 66 years of age and beyond. We think the sliding scale for new members offers an excellent recruiting tool to approach new physicians. The schedule for older members is another way we can say thank you for the many years of service to medicine in Georgia.

The Membership Committee continues to search for methods to enroll those Georgia physicians who have chosen not to belong to their medical societies. Membership recruitment letters are sent to each physician newly licensed in the state. Letters are sent to each county society as physicians move into their areas of jurisdiction.

The Membership Committee not only solicits new members but is concentrating on getting our current membership more involved. All MAG members under 40 years of age were sent letters challenging them to become involved and contribute their service to their medical societies.

Membership Report

	1977	*1976*	*1975*	*1974*	*1973*
Active	3,978	3,827	3,741	3,738	3,456
Active, I&R (Intern & Resident)	32	47	40	24	—
DE-1 (Financial Hardship/Illness)	60	61	65	59	63
DE-2 (Post-graduate Training)	10	15	15	19	21
DE-3 (Retired)	64	32	32	—	—
DE-4 (Temp. Duty, Armed Forces)	10	11	12	11	10
DE-5 (Life)	196	191	191	167	179
Associate	115	93	99	133	111
Service	66	66	62	55	65
Honorary	0	1	1	1	1
Affiliate	3	2	2	1	1
Student	3	2	2	2	1
TOTALS	4,547	4,348	4,262	4,210	3,908
AMA Membership	3,456	3,347	3,259	3,264	3,190

All physicians who have joined in the last two years were sent letters requesting they actively participate in their county, state and national medical organizations.

Representatives from each county society are invited to attend a membership workshop to be conducted prior to the official opening of the 1978 House of Delegates at Jekyll Island. Instructions have been sent to each county society secretary.

The work of the Membership Committee is a never-ending one. With this in mind we issue the recommendations listed below:

RECOMMENDATIONS

1. That each county medical society establish and maintain an active membership committee.
2. That each county society begin a viable membership recruitment drive with a goal of a 10% increase in members for 1978-79.
3. That each MAG member contact one non-member and in a face-to-face meeting, attempt to enroll said non-member into his medical societies.
4. That unity be our watchword and that we encourage membership at all levels—local, state, and national.
5. That each of us become not only members in name but in active participation.

REFERENCE COMMITTEE RECOMMENDATION:

The Membership Committee reports that the MAG and AMA membership continues to increase and makes five recommendations to increase both MAG and AMA membership.

Mr. Speaker, your Reference Committee advises that the Membership Committee report be adopted.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Membership.

Chairman Clark thanked all the members of the Reference Committee and expressed his appreciation to all those who appeared before his Committee who stated their views on the issues pending.





Members of Reference Committee D (left to right) Marvyn D. Cohen (vice chairman), John G. Bates, Philip Z. Israel, Ralph H. Tillman, William B. Spearman.

Report of Reference Committee D

Charles D. Hollis Jr., M.D., Chairman
Marvyn D. Cohen, M.D., Vice-Chairman

Chairman Hollis reported to the House of Delegates that Reference Committee D met in Colony Hall at the Holiday Inn on Jekyll Island on Friday, April 14, 1978, and carefully considered all the items referred to the Committee. The members of the Reference Committee present were: Charles D. Hollis Jr., M.D., Albany; Marvyn D. Cohen, M.D., Columbus; Ralph H. Tillman, M.D., Decatur; William B. Spearman, M.D., Atlanta; John G. Bates, M.D., Cuthbert; and Philip Z. Israel, M.D., Smyrna.

COMMITTEE ON PEER REVIEW

Walter S. Dunbar, M.D., Chairman

During the past year the Committee on Peer Review has continued to provide the development of medical policy for Peer Review, to serve as a final level for appeals, and to identify educational needs as demonstrated by Peer Review. Both individual claims and pattern of practice evaluations, when appealed, have been evaluated by this committee. Up to this time the educational benefits to be derived from the Peer Review mechanism have not been fully utilized, and suggestions made by the MAG Ad Hoc Committee on Peer Review reported elsewhere at this meeting may implement this need.

The Peer Review Committee has recommended this year that the definition of customary fee be maintained at this time as it has been in the past, namely, "that fee which is within a mutually agreeable percentile of usual fee charges for the same service by physicians of like specialty experience, located in the same geographical area."

The Georgia Medical Care Foundation has requested that guidelines be established in selecting consultants for review of claims by the Foundation. The Peer Review Committee recommended that the list of consultants volunteering for this activity be submitted to the appropriate specialty panels of the Foundation for their approval.

The Evaluation of New Procedures

In the summer of 1977, Blue Cross-Blue Shield identified a number of procedures, operations, and tests which were felt by them to be outmoded and therefore not worthy of payment. Partly in response to this, the MAG Committee on Peer Review at its June 9 meeting adopted a proposed mechanism for evaluation of new procedures, as well as outdated ones, to determine when a procedure becomes medically acceptable, and therefore compensable by third party carriers. This mechanism was reviewed briefly at the MAG Board of Directors meeting in January, 1978, and was referred to the House of Delegates without specific action for its consideration at its annual meeting in April, 1978.

RECOMMENDATIONS

The Peer Review Committee is submitting, for your consideration and approval, a mechanism for evaluating new medical procedures used in diagnosis or treatment of patients, as follows:

I. Each Specialty Society should designate, when indicated,

A) Recent procedures which are acceptable for reimbursement by third party carriers,

B) New procedures still unacceptable as yet for reimbursement, and

C) Outmoded procedures no longer warranted for reimbursement.

II. Each Specialty Society should set up a panel, or may

utilize panels within the Foundation, to review and evaluate these new or outmoded techniques of diagnosis or therapy.

III. The results of these evaluations and recommendations made by the Specialty Societies would be forwarded through the MAG Peer Review Committee, to third party carriers, urging their acceptance.

IV. Before the recommendations of the Specialty Society are submitted to third party carriers, the Peer Review Committee suggests that the following actions be taken:

A) The appropriate Specialty Society will stipulate that a new procedure or technique for diagnosis or treatment is no longer considered experimental, but is acceptable for medical care of patients.

B) The Society will define the criteria, if appropriate, for the proper utilization of the new procedure. These criteria should include:

1) Indications for the procedure.

2) The critical information necessary in the history, physical examination, and/or laboratory studies to substantiate indication for the procedure.

3) The designation of the medical care to be included, if appropriate, in the new procedure:

a) The estimated duration of the preoperative studies.

b) If a complication develops, to what extent is its management included in the procedure?

c) If readmissions to the hospital are required, is the care related to the re-admission included in the procedure?

d) The estimated post-operative length of stay in the hospital.

e) The designation of the duration of the post-treatment follow-up of the patient, which is to be included in the procedure.

As with the criteria for all procedures, the initial criteria should be modified as indicated by the re-evaluation of the procedure and its results. The MAG Committee on Peer Review recommends approval of this mechanism for the evaluation of new procedures.

REFERENCE COMMITTEE RECOMMENDATION:

The Committee on Peer Review has been active during the year, considering the effectiveness of the peer review mechanism and such specific matters as a method of selecting consultants for review as requested by the Georgia Medical Care Foundation. A specific problem arose when Blue Cross/Blue Shield identified some 28 procedures considered to be outmoded and therefore no longer reasonably compensable by the Blue Shield plan.

In an effort to deal with this, the Peer Review Committee devised a mechanism whereby the MAG through the specialty society panels could serve as an advisory body when matters of acceptability of outmoded or new procedures become questioned by third party payors. The Peer Review Committee recommends the method described below which it feels advisable to follow when MAG is consulted.

Mr. Speaker, your Reference Committee advises that recommendations by the Peer Review Committee be amended as follows:

I. Each specialty panel of the Georgia Medical Care Foundation, when consulted for advice, should review the challenged procedures and make appropriate recommendations.

II. The results of these evaluations and recommendations should be forwarded through the MAG Peer Review Committee to third party carriers for acceptance or rejection.

Mr. Speaker, your Reference Committee advises adoption of the recommendations of the Committee on Peer Review as amended.

HOUSE OF DELEGATES ACTION—Delegate Dan Jordan moved to amend Recommendation 1 of the Reference Committee by adding at the end of that recommendation the phrase "on a case-by-case basis." The House then voted to adopt the recommendation of the Reference Committee as amended.

The House then voted to reject Recommendation 2 of the Reference Committee.

COMMITTEE ON COMMUNICATIONS

Marvyn D. Cohen, M.D., Chairman

The Communications Committee is pleased to report on its activities for 1977-78. This year has been a busy one.

Although we lost our former Director of Public and Professional Relations (Charlie Templeton) in August, we added Ken Williams as the staff person in this position in October. Mr. Williams brings seven years background in education association activities to MAG.

MAGNET '77 was the best ever! Our program, Controlling Costs in Your Medical Practice, was evaluated by the participants as "valuable and informative" and the speakers were excellent. Those who failed to attend missed a great opportunity to improve the office efficiency of their medical practice.

Four years ago, the Communications Committee requested funds to provide refreshments to physicians taking the FLEX examinations in Atlanta. This year, we again provided refreshments, along with membership materials, to physicians registering to take the FLEX exams.

Through our public relations staff, we are producing our fourth set of public service radio health spots. These 30-second health-tip announcements are being distributed to the more than 200 radio stations across the state. These announcements are given free air time by the stations as a public service.

We have also distributed three public service announcements (PSAs) on video tape to each Georgia TV station. These PSAs were produced by the AMA for distribution by the state associations and edited in such a way to give MAG "credit for the message."

We co-sponsored a series of six workshops throughout the state for medical assistants entitled "Business Essentials for a Medical Office." These one-day sessions held in Atlanta, Columbus, Augusta, Savannah and Macon were conducted by Practice Productivity, Inc., and were designed to improve the quality of care given to patients through effective practice management.

Throughout the year, we monitor public attitudes, in one way, by the use of a statewide news clipping service. We, at every opportunity, look for opportunities to present medicine's story in the most appropriate manner. When necessary, we issue news releases on specific topics or issues and these are sent to each TV station, radio station and newspaper in Georgia.

Good media relations are an essential part of any strong public relations program. Good media relations is one

aspect of the Association's communications efforts that requires constant nourishment and cultivation. The requests from newspapers for information for articles is sporadic but increasing in frequency. MAG members are appearing on statewide radio on a weekly basis. We are also scheduling MAG members on Georgia's TV stations whenever possible.

MAG must continue to strive for a strong, positive, on-going public relations effort rather than being put on the defensive and always responding to criticism after the fact.

The communications committee's proudest accomplishment this year is the creation of a weekly, statewide radio show called FOR GOOD HEALTH. This five-minute, physician-interview program is broadcast each Saturday over the Georgia Network to over 100 affiliate stations. Each week a guest physician responds to questions posed by an interviewer on such health topics as colds, arthritis, anxiety/depression, smoking, weight control, etc. We expect that the show will not only allow MAG's name to be before the public each week, but the show should provide Georgians a greater understanding of the problems and issues affecting their personal well-being.

RECOMMENDATIONS

1. That MAGNET be continued with a practice management, public speaking, personal motivation format determined by the Communications Committee.
2. That our public service announcements (PSAs) be continued.
3. That the Communications Committee be given approval to proceed with the radio program FOR GOOD HEALTH and that the program not only be broadcast via the Georgia Network but that sufficient monies be allocated to distribute the program to selected "major market" stations.
4. That the Communications Committee be provided travel monies to tape the program FOR GOOD HEALTH in regional locations to broaden the involvement of MAG doctors.
5. That the president and the president-elect divide the state geographically in an appropriate manner, and that they be encouraged to make visitations to county medical societies and news media outlets.
6. That the Communications Committee serve as the coordinating committee for all other committees in dealing with matters of public interest.
7. That county medical societies be encouraged to utilize MAG staff to initiate public relations programs with local media.
8. That MAG's public relations efforts *concentrate* on an ongoing, positive program to include news releases, letters to the editor, radio and TV appearances of MAG representatives, etc., as opposed to the negative "responding after the fact approach."
9. That the Association continue its full support for viable communications plans developed by the Communications Committee.
10. That the name of the Communications Committee be changed to the Public Relations Committee.

REFERENCE COMMITTEE RECOMMENDATION:

The annual report of the Committee on Communications summarizes the Committee's activities, including planning of the 1977 MAGNET Conference, production and distribution of radio and television public service announcements on health, and the creation of a weekly statewide radio show, "For Good Health."

Recommendation 1 calls for the MAGNET Conference to be continued, and your Reference Committee advises that this recommendation be adopted.

In Recommendation 2 the Committee encourages continuation of the public service announcements, and the Reference Committee advises that this be adopted.

According to Recommendation 3, the radio program "For Good Health" has been effective and should be continued, and the Reference Committee advises adoption of this recommendation.

Recommendation 4: The Communications Committee feels that travel monies should be made available to tape the program "For Good Health," and your Reference Committee advises that this be adopted.

Recommendation 5: The Reference Committee amends this recommendation as follows: "The president and president-elect should be encouraged to visit as many county medical societies as possible and offer interviews to news media outlets when available." Mr. Speaker, your Reference Committee advises adoption of Recommendation 5, as amended.

Recommendation 6: The Communications Committee should serve as coordinator for all other committees in dealing with matters of public interest. Your Reference Committee advises adoption of this recommendation.

Recommendation 7: County medical societies should be encouraged to utilize the MAG staff to initiate public relations programs with local media. Your Reference Committee advises adoption of Recommendation 7.

Recommendation 8: Your Reference Committee amends Recommendation 8 as follows: "The MAG's public relations efforts should concentrate on an ongoing, positive program to include news releases, letters to the editor, and radio and television appearances of MAG representatives." Mr. Speaker, your Reference Committee advises adoption of Recommendation 8, as amended.

Recommendation 9: The Association should continue its full support for the viable communications plans developed by the Communications Committee. Your Reference Committee advises adoption of Recommendation 9.

Recommendation 10: The name of the Communications Committee should be changed to the Public Relations Committee. Your Reference Committee advises adoption of Recommendation 10.

The chairman of the committee stated in his testimony that, although his committee did not include it as a recommendation, the effectiveness of the committee's work would be improved significantly if it had available videotape equipment. Adequate supplies could be purchased for $3,000.00 at a maximum. Mr. Speaker, your Reference Committee would like to add a recommendation that the MAG purchase such equipment at a maximum cost of $3,000.00.

HOUSE OF DELEGATES ACTION—The House

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adopted Recommendations 1, 2, 3, 4, 6, 7, 9 and 10 of the Report of the Committee on Communications and adopted Recommendations 5 and 8 of the Committee Report as amended by the Reference Committee.

The Reference Committee amended the Report of the Committee on Communications by an additional recommendation that MAG expend $3,000 for the purchase of video tape equipment. The report of the Reference Committee was then amended on the floor by changing the period at the end of the Reference Committee recommendation into a comma, and adding the following language, "and that we adopt the report of the Reference Committee and refer it to the Board of Directors for implementation within the fiscal constraints of the budget we will adopt (tomorrow)."

COMMITTEE ON SCIENTIFIC ASSEMBLY

E. Napier Burson Jr., M.D. Chairman

1977 MAG Scientific Assembly

For the third successive year the MAG's Division of Education organized and sponsored a Scientific Assembly, held November 17-20, 1977, at the Omni International Hotel in Atlanta. Judging by the quality and number of programs and by the record attendance, this was the most successful MAG scientific meeting ever, and our thanks should go to the Assembly Chairman, Carter Smith Jr., M.D., and the Committee on Scientific Assembly, who worked so capably in planning the meeting.

The 1977 Assembly included programs in 17 specialties, with topics and speakers selected by program chairmen representing the respective specialty societies. As in the past, the MAG provided publicity, meeting space, audiovisual equipment, registration service, and speakers funds for the programs. Featured at the MAG Luncheon was the annual Abner W. Calhoun Lecture, delivered by Dr. Timothy Johnson of Harvard Medical School on the subject of the medical profession's reponsibility for educating the public about health.

Eight hundred and ninety-one people registered for the 1977 Assembly, an increase of 363 from the previous year. Of the total number, 633 paid registration fees, 92 were speakers, and 118 were interns or residents. Of the physicians paying registration fees, 468 are MAG members, 309 are from outside of the Atlanta area, and 70 from out of state (an increase of over 1000% from the previous year). The number of registered attendees at individual scientific programs ranged from five to 158 (Pathology).

The amount budgeted for the Assembly was $12,400.00. Actual expenditures were $22,226.61. Since gross receipts (including registration fees and contributions from pharmaceutical firms) totalled $16,155.00, the cost of the meeting to the MAG was $6,071.61—about $800.00 more than the previous year but less than half of the amount budgeted.

Included in expenditures was $10,800.63 for the educational programs of the various specialty societies. The committee regards these "speakers funds" as essential to the participation of the specialty societies, the quality of the education offered, and the overall attendance at the Assembly.

1978 Assembly

The 1978 Scientific Assembly will be jointly sponsored by the MAG and the Southern Medical Association and will be held November 11-14 at the World Congress Center in Atlanta. All the specialty societies in Georgia will be participating in planning the section programs, and due credit will be given in all publicity to both the MAG and the Georgia specialty societies. There will be no registration fee for either MAG or SMA members. The fee for non-members will be $20. Anticipated attendance is 3,500. Assembly Chairman is E. Napier Burson Jr., of Atlanta.

The financing of the 1978 Assembly is principally the responsibility of the Southern Medical Association, with the MAG to provide only staff assistance and publicity in Georgia up to a maximum of $10,000. We invite all MAG members to take advantage of this excellent educational opportunity.

Survey of Membership

The 1977 MAG House of Delegates approved a recommendation that the Committee on Scientific Assembly, in conjunction with the Education Committee, survey the MAG membership on the value of the Scientific Assembly, its continuance, and alternative approaches for MAG to support continuing medical education. This survey was conducted in December, 1977, and January, 1978, with an excellent response of almost 1,700 (or 37%) of the members. The results are being cross-tabulated by computer and should be available in time for the 1978 House of Delegates. MAG's Division of Education has already manually tabulated some of the questions, and these results follow.

When asked whether the Scientific Assembly was worthwhile continuing medical education and a good expenditure of MAG funds, 35% of the respondents answered that it was and 6% that it was not, with 42% declining to answer on the basis of insufficient knowledge. The remaining 17% answered that the Assembly has some value but could be improved in specific ways.

When asked whether the Scientific Assembly should be continued, 55% responded affirmatively, 5% responded negatively, and 35% expressed no opinion.

The members were also asked whether, *if* in the event the Scientific Assembly were to be discontinued, the MAG should or should not spend the funds on other educational activities. Only 17% responded that it should not, with the remaining 83% either responding that it should or not responding. The Education Committee is in the process of studying the numerous suggestions about the kinds of educational activities to which the MAG might give its financial support.

Preliminary analysis of the survey would seem to indicate that the MAG membership generally considers the Scientific Assembly a worthwhile expenditure of funds and is in favor of its continuation.

RECOMMENDATION

Considering the excellent attendance at the 1977 Assembly and the results of the recent all-member survey on the value of the annual MAG Scientific Assembly, the MAG should continue to provide full organizational and financial support for this yearly educational activity.

REFERENCE COMMITTEE RECOMMENDATION:

The Annual Report of the Committee on Scientific Assembly evaluates the 1977 MAG Scientific Assembly, describes the plans for the 1978 Assembly, and

summarizes the results of the recent MAG Survey on continuing medical education, insofar as it affects future planning for the Scientific Assembly. The report had only one recommendation, but the committee chairman did comment in testimony before the Reference Committee that the proliferation of continuing education meetings eventually will diminish support for all such programs. He felt that his Committee, or an ad hoc committee, should look critically at the continuing education programs sponsored by MAG and other organizations in the state and should consider the feasibility of coordinating planning among various groups. In time, it might be desirable for the MAG to act as a clearinghouse for organizations planning educational meetings.

The report concludes with the recommendation that because of the excellent support of the 1977 Scientific Assembly and the positive response regarding effectiveness of the Assembly in the recent all-member survey, the MAG should continue to provide full organizational and financial support for this activity. Mr. Speaker, your Reference Committee advises adoption of this recommendation.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Committee on Scientific Assembly.

COMMITTEE ON CANCER

J. Moultrie Lee, M.D., Chairman

The Committee received a report from Dr. S. Angiers Wills on the Governor's Cancer Advisory Committee of which Dr. Wills is chairman. The Cancer Advisory Committee is to give advice on the following matters to the commissioner of human resources.

A. Develop standards for determining eligibility of patients for care and treatment under this program.

B. Set standards for the equipment and staffing at Cancer Clinics located throughout the State. When they meet the standards, they will be certified by the DHR.

C. Extend financial aid to persons suffering from cancer by obtaining the medical, nursing, pharmaceutical and technical services necessary for caring for such a disease.

D. Criteria and procedures for financial aid will be developed by the division in accordance with the principle that economic distribution will subvert the rehabilitation purposes of this program and be more costly to the state in the long run.

E. Assist in the development and expansion by grant or contract of programs for the care and treatment of persons suffering from cancer so that more efficient and effective treatment may be offered to patients certified as eligible.

F. Assist in cancer prevention programs.

G. Assist in the development executions of programs for the early detection of cancer such as BSE-Cervix.

H. Institute and support directly or through health organizations such as ACS, GCMN educational programs.

I. Support a Statewide Registry.

RECOMMENDATION 2

Cancer Advisory Committee

The Cancer Committee unanimously recommends that the MAG support the Governor's Cancer Advisory Committee and recommends that adequate state appropriations

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be made to meet the objectives of the Cancer Advisory Committee.

The National Cancer Institute has a national program called "Cancer Information Service." This program handles questions about cancer primarily from the general public but also from physicians. The coordinator of this program from its Miami, Florida, headquarters has begun investigation towards spreading this NCI supported program into Georgia. She explained this program to the Chairman and several other members of the Committee. She is seeking approval of both the Medical Association of Georgia and the Georgia Division of the American Cancer Society prior to instituting the program.

RECOMMENDATION 3

The Cancer Information Service Program seems worthwhile but the Cancer Committee recommends that the Medical Association of Georgia investigate this program further prior to giving its approval.

REFERENCE COMMITTEE RECOMMENDATION:

The Annual Report of the Committee on Cancer summarizes the activities of both the committee and the Governor's Cancer Advisory Committee. Recommendations 2 and 3 by the Committee were considered by Reference Committee D.

Recommendation 2 recommends continued MAG support of the Governor's Cancer Advisory Committee and adequate state appropriations to support activities of the Advisory Committee. Your Reference Committee supports the concept of the Medical Advisory Committee to the State Government, but has reservations about committing itself to the support of policy and actions which might be formulated by the Advisory Committee in the future.

Mr. Speaker, your Reference Committee advises adoption of Recommendation 2 with the understanding that this does not imply that MAG support policies which have not yet been formulated by the committee.

Recommendation 3: The Committee recommends further investigation by the MAG into the Cancer Information Service Program. This arm of the National Cancer Institute provides answers by telephone to the general public on various general questions about cancer. Your Reference Committee heard testimony that the Cancer Information Service Program will be activated in Georgia and that by offering its support your Association would be able to monitor the activities and advise the program about aspects in which the profession is interested. There was considerable reservation about the worth of this type of activity by government agencies. However, it was felt that MAG should support the Cancer Information Service Program in order to have input into it.

Mr. Speaker, your Reference Committee advises amending Recommendation 3, by substitution, as follows: "MAG should approve the Cancer Information Service Program and request the opportunity to consult in the planning and implementation of this pro-

gram." Mr. Speaker, your Reference Committee advises adoption of Recommendation 3, as amended.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 2 of the Report of the Committee on Cancer with the understanding that adoption does not imply that MAG support the policies which have not yet been formulated by the Governor's Cancer Advisory Committee.

Adopted Recommendation 3 by floor substitute offered by Delegate F. William Dowda. The floor substitute refers Recommendation 3 to the MAG Board of Directors for adoption when further information is available and considered.

COMMITTEE ON EDUCATION

LaMar S. McGinnis Jr., M.D., Chairman

This Committee is charged by the Association as follows: "The Education Committee shall work to foster the development of high quality continuing education programs for physicians throughout the state. It shall also promote comprehensive health education in the schools, patient education, and health education for the general public. The Committee shall maintain liaison with the medical schools and with other institutions and agencies which provide medical and health education."

We have been extremely pleased with the active interest and participation by the 36 members of our large committee. Attendance at our quarterly meetings is outstanding, and our general meetings are preceded by meetings of subcommittees which carry on a large portion of the work of the Committee. Physicians are extremely conscious of their educational efforts presently, and this is true not only in our state but nationally as well. Thirty-seven states now have requirements for certain amounts of continuing medical education (CME) for re-licensure or membership in the state medical society. With this continuing and increasing emphasis on education, the members of our association look to the organization for leadership in this regard. The November "Education Issue" of the MAG *Journal* detailed the wide range of interests and activities of this committee: our annual Scientific Assembly; public health education; patient education; liaison with our state medical schools; a medical library program for small hospitals; accreditation of CME programs; and the cornerstone of our program—the improved availability of CME programs at the local level.

Following is a summary of Committee activities during the past year:

Subcommittee on Accreditation

1) Conducted CME accreditation surveys of two hospitals (Tanner Memorial, Carrollton; University Hospital, Augusta) and one specialty society (Georgia Rheumatism Society).

2) Conducted re-surveys of five already-accredited organizations.

3) Received accreditation applications from three hospitals and two specialty societies which revealed deficiencies indicating unreadiness for accreditation; provided consultation to these organizations on how to prepare for accreditation.

4) Sent accreditation application materials to eight hospitals and eight specialty organizations upon request.

To date, the following hospitals and organizations have been accredited through the Medical Association of Georgia for their CME programs:

American Academy of Pediatrics, Georgia Chapter
American Cancer Society, Georgia Division
Atlanta Graduate Medical Assembly
Atlanta Society of Pathologists
DeKalb General Hospital, Decatur
Georgia Academy of Family Physicians
GAFP Educational Foundation
Georgia Baptist Hospital, Atlanta
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology
Georgia State Obstetrical and Gynecological Society
Georgia Surgical Society
Martin Army Hospital, Fort Benning
The Medical Center, Columbus
Medical Center of Central Georgia, Macon
Memorial Medical Center, Savannah
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
Southeastern Angiographic Society
Tanner Memorial Hospital, Carrollton
University Hospital, Augusta

The Subcommittee, chaired by Dr. James Maughon, has demonstrated extreme diligence and concern in the work of accreditation and in educational activities preparing organizations and hospitals for accreditation.

Subcommittee on Hospital Continuing Medical Education

1) This Subcommittee, chaired by Dr. Dan Cabaniss, is attempting to increase the number of hospitals and organizations with accredited CME programs. The above list indicates those hospitals accredited, but the fact that there are over 87 hospitals in the state with 75 beds or more, and 36 hospitals with over 150 beds, would indicate that still many hospitals must be reached and assisted in establishing accredited educational programs.

2) The MAG Director of Education has traveled to a number of hospitals to promote CME and accreditation: LaGrange, Newnan, Moultrie, Bainbridge, Thomasville, Valdosta, Douglas, Brunswick, and four hospitals in the Atlanta area.

3) The Committee, through the work of Dr. Nicholas Davies, continued to emphasize the establishment of consortia of medical libraries for small hospitals.

General CME Activities

1) A medical meeting calendar of all CME courses in the Southeast is maintained and published monthly in the MAG *Journal*.

2) A special education issue of the *Journal* was published in November 1977.

3) An all-member survey on CME was conducted in early 1978 and will be alluded to later in this report.

4) The Education Committee, and particularly the Director of Education, worked with the MAG Committee on Scientific Assembly, chaired by Dr. Carter Smith Jr., to put on a most successful 1977 Scientific Assembly, attended by 891 registrants in 17 specialty sections. The 1978 Assembly will be a joint meeting with the Southern Medical Association, the first meeting of this kind attempted by the SMA.

5) The MAG sponsored two practice management workshops for housestaff preparing to enter private practice.

6) The MAG promoted the Physician's Recognition

Award by adding an MAG seal and cover letter to each PRA certificate awarded to a Georgia physician by the AMA.

7) Members of the Education Committee testified before the Composite State Board of Medical Examiners on the question of mandatory CME for re-licensure.

8) The MAG Division of Education sponsored a CME exhibit at the MAG Scientific Assembly and at the Atlanta Graduate Medical Assembly.

9) The Education Committee is studying the feasibility of using the MAG computer facilities to maintain a cumulative record of each MAG member's CME credit hours for various programs attended.

Subcommittee on Health Education

This Subcommittee, through the active interest of Drs. Nicholas Davies and John Harrel and other committee members, has attempted to increase MAG participation in efforts to improve health education in the schools, patient education, and general public health education.

1) County medical societies have been encouraged to establish education committees to work with local school boards, PTAs, etc., in improving health education curricula in the schools.

2) Hospital staffs have been encouraged to establish patient education committees and/or departments to improve the health education of this captive audience and their visitors.

3) Interested members of the subcommittee have continued to meet with representatives of various health and education groups within the state to attempt to improve organized medicine's input into the health education planning process. MAG's Director of Education participated actively with a committee of the state PTA to increase awareness among parents and local school officials of the need for comprehensive school curricula in education.

4) MAG's Director of Education organized and sponsored an educational program on cancer for all MAG employees.

Subcommittee on Medical Schools

The Education Committee felt that the Biennial Conference on Medical Education was no longer needed; however, a reactivation of the Subcommittee on Medical Schools was accomplished, with Dr. Lois Ellison as chairman, to continue to maintain liaison with the medical schools in our state. Representatives from the Medical College of Georgia, Emory University School of Medicine, the School of Medicine at Morehouse College, and the proposed Mercer University School of Medicine have been attending these meetings. Student and housestaff members have recently been added to this committee and are actively participating. A comparative study of the educational objectives of these schools has been carried out, and considerable discussion regarding each school's particular philosophy in regard to family practice has taken place.

Survey of Membership Regarding Continuing Medical Education

The committee conducted an all-member survey of the MAG on continuing medical education in January, 1978. Thirty-seven percent (1,650) of the surveys were returned—an excellent response for a "non-gut issue." A computer analysis of the survey is presently being done,

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and we hope to have a complete report ready by the time of the MAG Annual Session in April. Of interest is that, of those responding, the majority favored some form of mandatory CME. There was strong support for the MAG Scientific Assembly with an indication that it should be continued. Approximately half of the physicians indicated that they were not able to participate in as many CME activities as they desired. Reading journals and textbooks is the most favored form of continuing education, and there is strong support of specialty society meetings and in-hospital CME programs. The information received in this survey should be extremely helpful in future planning of MAG educational activities.

Proposed Seminar on the Marketplace of Medicine

Faculty members of the Department of Private Enterprise at Georgia State University presented in discussion before the committee a proposal to organize and conduct a seminar for physicians to be entitled "Private Enterprise and the Medical Profession." The seminar, to be sponsored by the MAG, would give practicing physicians an opportunity to learn from experts in the field about our economic system and the political forces it sets in motion. Only topics that are new and relevant to physicians would be presented, such as the profit motive, competition, the law of supply and demand, price regulation, and the future development of economic alternatives in the medical marketplace.

The committee is enthusiastic about the potential for such a program, provided it is supported by the MAG as a whole. We believe that the majority of MAG members' needs for scientific continuing education are fairly well met by the numerous programs available both inside and outside the state, and yet few of us have either taken the trouble or had the opportunity to receive education which would give us a broad understanding of the economics of our profession. This education would be most timely in view of the increasing pressures being put upon us by government agencies, lawmakers, third party payors, and consumers with regard to the cost of health care. We believe this is one of the most worthwhile projects MAG could initiate, with long-range value affecting many concerns of the membership as well as the public stature and credibility of our profession. The seminar could be conducted once on a pilot basis and later repeated if it proves successful.

RECOMMENDATIONS

1) That the MAG continue to provide support, financial and otherwise, to the increasingly important educational activities of the association.

2) That the MAG continue to encourage county medical societies to establish committees on health education to actively pursue the development of school and public health education projects in each local community.

3) That the MAG encourage hospitals to establish patient education committees and/or departments to improve the availability of health education to patients and their visitors.

4) That the MAG sponsor a seminar on "Private En-

terprise and the Medical Profession'' for invited members of the county medical societies. The seminar would be organized and conducted by the Chair of Private Enterprise at Georgia State University and administered by the MAG Division of Education and would be held on a fall weekend at a site such as Lake Lanier or Callaway Gardens. Fiscal note: Cost to MAG would be $690.00 for publicity, staff, and reception, with the faculty expenses to be recouped through a registration fee of $50 for each MAG attendee.

5) That the MAG consider the addition of a staff position, full-time or part-time, with responsibility divided in the areas of public relations and education. This person would work with the Education Division and Public Relations Department to give the MAG visibility throughout the state as a promoter of good health for our citizens. He or she would strive to increase communication between the MAG, the county medical societies, the public media, school boards, educational organizations, and public and private health agencies, with the objective to increase the quality and availability of sound health education for patients, elementary and secondary school students, and the general public.

6) That the MAG acknowledge and respond to the important information contained in the computer analysis of the recent survey on continuing medical education.

REFERENCE COMMITTEE RECOMMENDATION:

The Annual Report of the Committee on Education describes comprehensively the Committee's activities in the areas of continuing medical education, CME accreditation, practice management workshops for residents, liaison with the medical schools, and health education for the public. It also summarizes the results of the recent all-member survey on CME and outlines a proposal for a seminar on the economics of the medical profession. Recommendations 1, 2, and 3 call for the MAG to continue its support of the association's educational activities, to continue to encourage the county medical societies to promote health education in schools, and to encourage hospitals to establish patient education activities.

Mr. Speaker, your Reference Committee advises adoption of these three recommendations.

Recommendation 4 calls for the MAG to sponsor a fall seminar on ''Private Enterprise and the Medical Profession'' for invited members of the county medical societies. Your Reference Committee advises amending Recommendation 4 as follows: ''The MAG Committees on Education and Communications should work cooperatively toward incorporating a seminar on 'Private Enterprise and the Medical Profession' into the program for the MAGNET Conference 1978.''

Mr. Speaker, your Reference Committee advises adoption of Recommendation 4 as amended.

Recommendation 5 asks the MAG to add a staff position in the combined areas of public relations and health education. Your Reference Committee advises amending by substitution Recommendation 5 as follows: ''The MAG Committees on Education and Communications should re-assess the duties of the present staff members involved in education and public relations activities, and consider changing priorities of certain assignments. The purpose would be to make more time available for staff to work in the areas of education, especially in the schools, and in public relations activities throughout the state.

Mr. Speaker, your Reference Committee advises adoption of Recommendation 5, as amended by substitution.

Recommendation 6 asks that the MAG acknowledge and respond to the important information obtained from the recent survey on continuing medical education. At the Reference Committee hearings supplementary information from the Education Committee was submitted to discuss the results and implications of the survey. Your Reference Committee advises amending by substitution Recommendation 6 as follows: ''Because of the surprising interest by the membership in mandatory continuing medical education, the Education Committee should investigate various alternatives as to how the MAG might approach the question of mandatory continuing medical education. The result of this further study by the Committee should be reported to the 1979 House of Delegates. The supplementary statement of the Committee on Education should be published in its entirety in the *Journal* of the Medical Association of Georgia.''

Mr. Speaker, your Reference Committee advises adoption of Recommendation 6 as amended.

HOUSE OF DELEGATES ACTION—Adopted Recommendations 1, 2, and 3 of the Committee Report. Adopted Recommendation 4 as amended by the Reference Committee. Adopted Recommendation 5 as amended by the Reference Committee.

Delegate Ronald Galloway moved to amend the amended Recommendation 6 by deleting the phrase, ''because of the surprising interest by the membership in mandatory continuing medical education,'' and by changing the word ''question'' to ''value.'' The Galloway amendment was adopted. Recommendation 6 was then adopted by deletion and substitution. Delegate F. William Dowda then moved to refer the entire subject to the Board of Directors for evaluation and report its recommendations back to the next meeting of the House of Delegates. The Dowda amendment was adopted.

LIAISON COMMITTEE TO EUGENE TALMADGE MEMORIAL HOSPITAL

C. Emory Bohler, M.D., Chairman

The Eugene Talmadge Memorial Hospital Liaison Committee is composed of Representatives of the Executive Committee of the Hospital including the President and Dean of the Medical College of Georgia; the Administrator and Comptroller of the Hospital and Representatives of various departments of the Medical College of Georgia plus three actively practicing physicians from about the State.

The Committee meets quarterly and is primarily concerned with providing hospital services for referred patients from the physicians of Georgia.

We realize there have been problems in the past with physicians unable to get patients accepted at Eugene Talmadge Memorial Hospital, but we believe this has been overcome and in our opinion availability of services has

now occurred since completion of the Sydenstricker Wing of the Hospital.

A Eugene Talmadge Memorial Hospital-Medical College of Georgia telephone directory has been completed and sent to referring physicians to facilitate referrals.

We shall continue to strive to improve relations between the practicing physicians of Georgia and the Eugene Talmadge Memorial Hospital-Medical College of Georgia facilities.

REFERENCE COMMITTEE RECOMMENDATION:

The Annual Report of the Liaison Committee on the Eugene Talmadge Memorial Hospital notes the fact that the committee has been meeting regularly each quarter and has effectively corrected some of the problems encountered by physicians in referring patients to Eugene Talmadge Memorial Hospital. In discussion before the Reference Committee, it was noted that the expansion of facilities makes it much easier to accept referrals from around the state, but that even the newer and larger facilities are ultimately limited. In the discussion it was also emphasized that referral of private and partial pay patients is encouraged, since state funds are not sufficient to support all the activities of the hospital. It was reported that a central referral number (404-828-2419) is now available to expedite the referral process. Testimony revealed that a large percentage of the faculty of the Medical College of Georgia is active in the Richmond County Medical Society and the MAG.

Mr. Speaker, your Reference Committee would like to thank the physicians on the faculty of the Medical College of Georgia for their active and effective participation in affairs of MAG. Your Reference Committee advises that this report be filed for information.

HOUSE OF DELEGATES ACTION—Report of the Liaison Committee on the Eugene Talmadge Memorial Hospital was filed for information.

RESOLUTION 28
SMOKING IN HEALTH CARE FACILITIES

DeKalb Medical Society

WHEREAS, in 1977, the House of Delegates passed a resolution directing physicians to attempt to eliminate cigarette smoking in all health related facilities, i.e., hospitals, clinics, nursing homes, private offices, medical schools, medical meeting places, etc., NOW THEREFORE BE IT

RESOLVED, that these facilities be polled to determine what efforts are being made to eliminate or reduce smoking in their respective facility, and BE IT FURTHER

RESOLVED, that a report on the findings of the survey be presented at the 1979 House of Delegates.

REFERENCE COMMITTEE D

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 28, presented by the DeKalb Medical Society, refers to a resolution passed by the 1977 MAG House of Delegates, directing physicians to attempt to eliminate cigarette smoking in all health facilities. It calls for a survey of the facilities to determine what efforts are being made to eliminate smoking, the results of the survey to be presented to the 1979 House of Delegates.

Mr. Speaker, your Reference Committee advises that this resolution be amended as follows: "Resolved, that the MAG, through its *Newsletter* and its monthly *Journal*, provide a survey form for MAG physicians to be polled as to the effectiveness of their campaign to eliminate smoking in physicians' offices and other health facilities. The form for conducting this poll should be developed by the Education Committee. The results should be reported in a subsequent issue of the MAG *Journal*." Mr. Speaker, your Reference Committee advises that Resolution 28 be adopted as amended.

HOUSE OF DELEGATES ACTION—Adopted Resolution 28 as amended by the Reference Committee.

Chairman Hollis thanked the members who served on the Reference Committee and those who appeared before the Committee to express their views. He also thanked staff for their assistance and advice.

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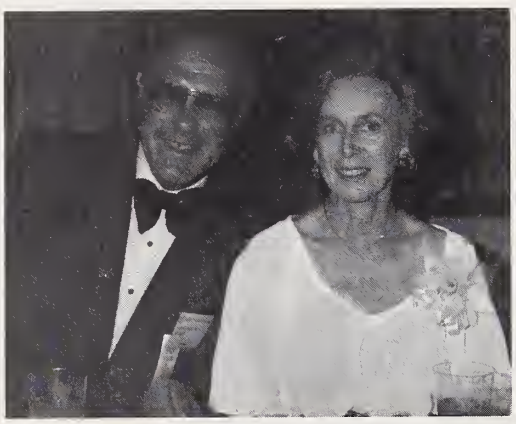


Top—President-Elect Carson B. Burgstiner and wife Jacque; President Milton I. Johnson. Center—Secretary Earnest Atkins shares his last drop of Michelob with AMA Vice Speaker Harrison L. Rogers Jr. Bottom—Russell E. Andrews and wife Betty (president AMAG); Speaker L. C. Buchanan and wife Mary.













MAG Annual Banquet

THE ANNUAL BANQUET of the Medical Association of Georgia was held in Colony Hall at the Holiday Inn on Jekyll Island, Saturday, April 15, 1978.

The invocation was offered by Dr. Rupert Bramblett of Cumming, Georgia.

Following dinner, President Milton I. Johnson introduced those sitting at the head table as follows: President-Elect Carson B. Burgstiner and Mrs. Burgstiner, Immediate Past President Fleming L. Jolley and Mrs. Jolley, Second Vice President L. Newton Turk and Mrs. Turk, Chairman of the Board Joe C. Stubbs and Mrs. Stubbs, Secretary Earnest C. Atkins and Mrs. Atkins, Treasurer James H. Sullivan and Mrs. Sullivan, Speaker of the House L. C. Buchanan and Mrs. Buchanan, Vice Speaker of the House Jack Mendez and Mrs. Mendez, Vice Chairman of the Board of Directors Jack Raines and Mrs. Raines, President of the MAG Auxiliary Mrs. Russell Andrews and Dr. Andrews, Mrs. Milton I. Johnson and Mrs. Robert E. Perry.

Family Physician of the Year Award

Dr. Johnson then called on Stephen C. May, President of the Georgia Academy of Family Physicians, who presented the Family Physician of the Year Award. Dr. May announced that the recipient of the 1978 Family Physician of the Year Award was Dr. Wells Riley of Jonesboro, Georgia. Dr. Riley made brief remarks in accepting the award.

Certificates of Appreciation

Dr. Johnson then presented a gold President's Key inscribed to Dr. Robert E. Perry, Jr. to Mrs. Alice Carroll Perry, and then called on Dr. Earnest C. Atkins to announce the recipients of the Certificate of Appreciation Awards. Dr. Atkins announced that Certificates of Appreciation were being awarded to: M. C. Adair of Rome, as chairman of the Access to Health Care Committee; Stanley P. Aldridge, Decatur, as alternate director to the MAG Board of Directors; Edwin W. Allen Jr., Milledgeville, as director to the MAG Board of Directors; Mrs. Russell E. Andrews, Rome, as president of the MAG Auxiliary; Earnest C. Atkins, Atlanta, as secretary of MAG; J. Daniel Bateman, Albany, as GaMPAC chairman; Carson B. Burgstiner, Savannah, as president-elect of MAG; Congressman John J. Flynt Jr., Griffin, for a longstanding interest in medical legislation; William R. Hardcastle, Tucker, as a member of the Board of Directors of the Georgia Medical Care Foundation; M. A. Hubert, Athens, as alternate director to the MAG Board of Directors; Milton I. Johnson Jr., Macon, as MAG vice president and MAG president; John R. McCain, Atlanta, as secretary to the Georgia Medical Care Foundation Board of Directors; Harvey M. Newman, Gainesville, as director to the MAG Board of Directors; Robert E. Perry Jr., Brunswick, as MAG's president; Carter Smith Jr., Atlanta, as chairman of the MAG Scientific Assembly; Luther M.

Thomas Jr., Augusta, as vice president of the Georgia Medical Care Foundation; and Luther M. Vinton, Avondale Estates, as a member of the MAG Board of Directors.

Civic Endeavor Award

Dr. Johnson called on President-Elect Carson Burgstiner to announce the recipient of the 1978 MAG Civic Endeavor Award. Dr. Burgstiner noted that the Civic Endeavor Award would be presented posthumously to J. Rufus Evans of Stone Mountain, Georgia, and presented the award to Dr. Evans' daughter, Mrs. H. Duane Blair.

Fifty Year Certificates

Dr. Johnson then announced that the recipients of the Fifty Year Certificates would be: Hugh J. Bickerstaff, Columbus; William C. Boswell, Macon; James M. Byne, Jr., Waynesboro; Walker L. Curtis, College Park; Leila A. D. Denmark, Atlanta; Edgar M. Dunstan, Decatur; James F. Hanson, Macon; Robert M. Harbin Jr., Rome; Ernest A. Hensley, Gibson; William H. Kiser Jr., Atlanta; John C. Ivey, Meansville; William R. McGinty, Moultrie; Lila Bonner Miller, Atlanta; Burch J. Roberts, Toccoa; Shelton P. Sanford, Athens; Tofey G. Smaha, Griffin; M. Evelyn Swilling, Macon; David O. Thompson, Atlanta; Elbert Van Buren, Atlanta; Hoke Wammock, LaGrange, and D. Lloyd Wood, Dalton.

Life Members

Dr. Johnson then announced that the following had been awarded Life Membership in MAG: Stephen T. Barnett Jr., Atlanta; Needham Bateman, Atlanta; Dave Berman, Columbus; Jack K. Bleich, Atlanta; L. Render Braswell, Atlanta; Clyde L. Crawford, Atlanta; C. Dixon Fowler, Atlanta; Wadley R. Glenn, Atlanta; Lester Harbin, Rome; James B. Harris, Atlanta; McClaren Johnson, Atlanta; William K. Jordan, Macon; Rose A. Lahman, Atlanta; Mason I. Lowance, Atlanta; Harry C. Lyon, Atlanta; A. Park McGinty, Atlanta; F. Earl McLendon, Atlanta; W. C. Mitchell, Smyrna; R. W. Moore, Savannah; Philip H. Nippert, Atlanta; Buford L. O'Neal, Atlanta; and Joseph Pacifici, Columbus.

Dr. Johnson then introduced the featured speaker for the evening, Dr. John H. Budd of Cleveland, Ohio, president of the American Medical Association. Following Dr. Budd, Dr. Johnson delivered an address to the group at the conclusion of which he announced that the banquet was adjourned.









Left—(top to bottom) Chairman of the Board Joe C. Stubbs and wife Tilda; Second Vice President L. Newton Turk III and wife Marcie; Vice Speaker of the House Jack Menendez and wife Connie; Emy (Mrs. H. Duane) Blair accepts the Civic Endeavor Award presented posthumously to her father, John Rufus Evans, as President-Elect Carson B. Burgstiner looks on.

Right—(top to bottom) Vice Chairman of the Board Jack A. Raines and wife Jean; Braswell E. Collins and wife Lucy; T. A. Sappington, Past President W. C. Mitchell and wife Millie; President Milton Johnson presents certificate of appreciation for the late President Robert E. Perry to Mrs. Alice Carol Perry.

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GaMPAC Breakfast

THE FIFTH ANNUAL GaMPAC Breakfast was held Sunday morning, April 16. Over 350 people attended.

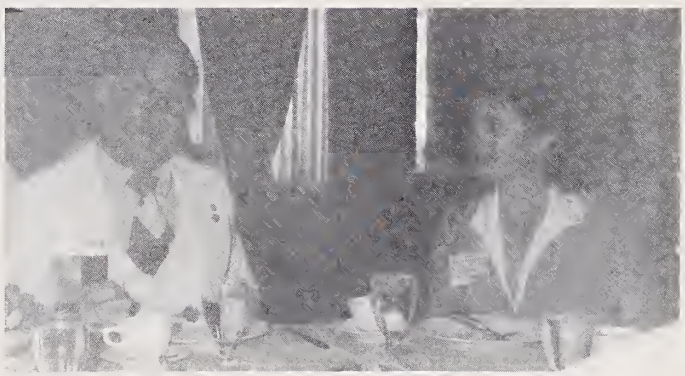
Ken McDonald, M.D., Augusta, GaMPAC Chairman, was M.C.

John "Pepper" Martin, M.D., Augusta, introduced the guest speaker, Senator Sam Nunn, who spoke on a variety of political issues of concern to physicians. He discussed in depth the status of national health insurance legislation and explained reasons why he does not support NHI at this time.

Senator Nunn emphasized the importance of GaMPAC and said, "every physician should be a member." He also answered several questions from the audience.











Pictured: Top—(left to right) John "Pepper" Martin, Sam Nunn; center—Carson B. Burgstiner and wife Jacque; bottom—W. C. Mitchell, attendees at the buffet table.

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Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

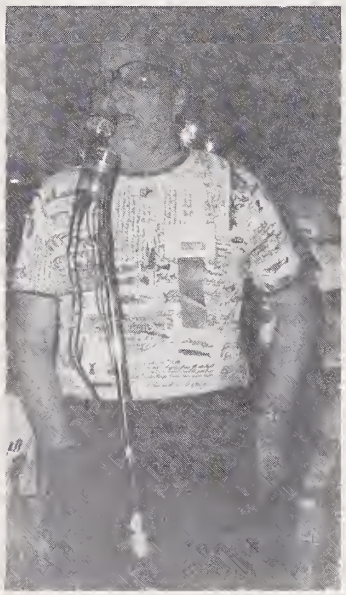
Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Final Session House of Delegates
Sunday, April 16, 1978







Delegates express their views on matters before the House. Pictured (left to right) are AMA Delegate F. W. Dowda, Chairman of the Legislative Committee James A. Kaufmann, Chairman of the Committee on Health Planning J. W. Chambers.

THE FINAL SESSION of the MAG House of Delegates 1978 meeting was called to order at 9:00 a.m. on Sunday, April 16, 1978 by Speaker L. C. Buchanan, in Colony Hall, Holiday Inn, Jekyll Island, Georgia.

The Reverend Hugh P. Garner, Pastor of the First Baptist Church of Brunswick, Georgia, delivered the invocation.

Speaker Buchanan asked for a report on attendance from Hugo S. Moreno, chairman of the Credentials Committee and Dr. Moreno responded that there were 183 delegates registered and present, representing 47 component county medical societies, and accordingly, that a quorum did exist.

Reference Committee Reports

Speaker Buchanan called for reports from the reference committee chairmen. The Speaker very briefly restated the procedure that would be followed; he announced that as soon as the results of the election were known, they would be reported from the podium, and then proceeded to call for reports from the reference committees in the following order:

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Members of Reference Committee B Alexander H. S. Weaver (chairman), Ronald F. Galloway.

Report of Reference Committee B

ALEXANDER H. S. WEAVER, M.D., Chairman
FRANK W. McKINNON, M.D., Co-Chairman

Chairman Weaver reported that Reference Committee B met in Colony Hall at Holiday Inn on Jekyll Island, Friday, April 14, 1978, and gave careful consideration to all the items referred to that Committee.

Members of the Reference Committee present included Alexander H. S. Weaver, M.D., Macon, Chairman; Frank W. McKinnon, M.D., Marietta, Co-Chairman; Joe L. Nettles, M.D., Savannah; Charles W. McDowell Jr., M.D., Decatur; William C. Collins, M.D., Atlanta; Ronald F. Galloway, M.D., Augusta.

OFFICE OF THE SECRETARY

Earnest C. Atkins, M.D., Secretary

As my sixth year as secretary nears an end, it continues to be apparent that the activities of the Medical Association of Georgia, both in number and complexity, are rapidly accelerating. The leadership ability of the members, Board of Directors, Executive Committee, committee chairmen, headquarters office staff, CHAMPUS staff, MAG Services, Inc. staff, and the staff of the Medical Care Foundation continues to be more and more evident. It is a genuine pleasure to serve with such dedicated and effective people.

The membership of the Medical Association of Georgia continued its upward climb during the year 1977. The membership grew by 4.9% during 1977 (whereas it grew by 2.3% in 1976). In 1977 we increased our active membership by 151 and our total membership by 189. In 1977 we increased our active membership to 3,978 and our total membership to 4,537. Our AMA membership is at an all time high, 3,456 in 1977, as compared to 3,347 in 1976, a net gain of 109. Estimated number of licensed physicians residing in Georgia as of the end of 1977 was 6,500.

Although we had a good membership year both at the MAG and AMA, the big concern to me is the 1,500 Georgia physicians who are not members. We should continue to serve our present membership even better and employ the advantages of organized medicine so that all physicians in Georgia will rally to swell our ranks.

CHART I

Membership Report

	1977	*1976*	*1975*	*1974*	*1973*
Active	3978	3827	3741	3738	3456
Active I&R	32	47	40	24	
DE-1	60	61	65	59	63
DE-2	10	15	15	19	21
DE-3	64	32	32		
DE-4	10	11	12	11	10
Life	196	191	191	167	179
Associate	115	93	99	133	111
Service	66	66	62	55	65
Honorary	0	1	1	1	1
Affiliate	3	2	2	1	1
Student	3	2	2	2	1
TOTALS	4537	4348	4262	4210	3908
AMA Membership	3456	3347	3259	3264	3190

CHAMPUS

The attached statistical report reflects a 13% increase in

volume of claims with an average 8.1% decrease in funds expended. This is due to emphasis placed on more frequent claims filing. Rather than allowing claims to build up for years or more, beneficiaries and providers are encouraged to file upon completion of care, monthly or quarterly depending upon individual's preference. The increase in medical review is due primarily to increased review requirements placed on psychiatric care by OCHAMPUS.

A completely new regulation for CHAMPUS was published in the *Federal Register* on April 4, 1977 and implemented, primarily, June 1, 1977. It was intended to more clearly define the extent of CHAMPUS benefits. The implementation of these regulations has created some problems. Some of these relate to termination or "tightening up" of benefits such as: limitation of payment for private duty nursing care if the hospital had an intensive care unit; non-payment for CAT scan, except for those of the brain, and then only if the scan was performed with hospital owned equipment and other non-invasive, less expensive diagnostic procedures have already been performed. More emphasis is placed upon actual *medical necessity*. For example, payment is no longer authorized for routine chest x-rays, EKG's upon admission to hospital unless patient is to undergo general anesthesia. Also surgical assistants must be medically required and interns and residents must be used when available. Partners/associates may be observed more closely and concurrent care by two or more physicians will be reviewed for medical necessity.

Also during 1977, the Department of Defense mandated that all CHAMPUS contracts be opened for competitive fixed-price bid. In the awarding of these contracts, OCHAMPUS also placed emphasis on utilization of multi-state contracts in an effort to "more effectively" manage the program. As a result of this, MAG became the last medical association to lose the CHAMPUS contract. Effective February 1, 1978, Mutual of Omaha, 3301 Dodge Street, Omaha, Nebraska 68131 began processing *all* CHAMPUS claims for Georgia. They have processed inpatient hospital claims since the inception of the program. They also process all claims for several other states. Because of their previous experience, we believe Mutual of Omaha will be able to process claims efficiently. However, MAG is deeply traumatized by the loss of the facility for direct personal contact with our own CHAMPUS employees.

(Please see chart on facing page)

MAG FOUNDATION

Facts about MAG Foundation, Inc., as of 12/31/77

	Term Expires
J. Rhodes Haverty, M.D., President	1978
Carson B. Burgstiner, M.D., Vice President	1979
Earnest C. Atkins, M.D., Secretary/Treasurer	1980
Mr. James M. Moffett	1982
Charles R. Andrews, M.D.	1983

The MAG Foundation (Benevolent) grows slowly but surely each year. The bank balance as of 31 December 1977 was $14,445.82, up from the 31 December 1976 balance of $11,422.93. $1,500.00 was donated to the Disabled Doctors Program by MAG physicians and friends of the program.

Statement of Funds in the Benevolent Foundation.

	1976	*1977*
Cash, Student Loan Fund	$ 2,476.46	$ 5,522.89
Notes Receivable, Student Loans	54,819.20	57,664.14
Total, Student Loans	$57,295.66	$63,187.03
Funds for Indigent Physicians	$11,422.93	$ 8,922.93
Loan to Indigent Physician		4,000.00
Total, Indigent Physicians	$11,422.93	$12,922.93

There is included in MAG's annual budget $1.00 per paying member to be allocated to the Foundation in order that a fund may be established to assist indigent physicians and physicians' widows.

The MAG Foundation also administers donations and loans to physicians for the Disabled Doctors Program.

Again, the Foundation expresses its gratitude to the various County Society Auxiliaries for their numerous contributions to the Scholarship Fund.

During 1977 three MAG physicians donated a total of $2,000.00 which has been credited to the Disabled Doctors Program.

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GEORGIA MEDICAL CARE FOUNDATION

Again, a separate report is given, but the fine spirit of cooperation between the Executive Secretary, Mr. John Voigt, and his staff, with MAG deserves attention and commendation.

HEADQUARTERS OFFICE

The Headquarters Building continues to serve as a focal point for the operations of the Association. With every segment of operation growing, expansion is the word of the day.

The Georgia Medical Care Foundation relocated to our building on January 1, 1977. In addition to the rental income, a close adhesiveness of these two organizations continues to exist.

Our Headquarters Office is continually growing in response to an enlarged membership and a vast number of projects and activities. The total personnel at MAG in the various related activities that are sponsored by MAG is 106. A breakdown of personnel by department is as follows:

CHART II

	1976	*1977*
MAG Auxiliary	1	0
MAG (including Secretary, Treasurer, and JMAG Editor)	17	18
CHAMPUS	37	43
Research & Development	11	9
GMCF	42	34
MAG Services, Inc.	2	2
	110	106

We are now contracting with the State of Georgia to operate the Cancer Registry.

MEDICAL ASSOCIATION OF GEORGIA—CHAMPUS 1976-1977 STATISTICAL REPORT

Claim Flow	*Annual*		*Average Per Month*		*Average Per Day*		*Percent of Total*		*Percent of Average Change*	
I Number claims received	1976	1977	1976	1977	1976	1977	1976	1977	1976	1977
1) Inpatient	36,364	36,682	3,030.3	3,056.8	145.5	146.7	30.0	27.0	(9.6)	—
2) Outpatient	66,928	80,101	5,577.3	6,675.1	267.7	320.4	56.0	59.0	4.2	19.7
3) Drugs (vendor or reimb.)	16,874	19.064	1,406.2	1,588.7	67.5	76.3	14.0	14.0	16.6	13.0
4) Handicap	145	115	12.1	9.6	.6	.5	—	—	(31.0)	(20.7)
Total	120,311*	135,962	10,025.9	11,330.2	481.3	543.9	100.00	100.0	1.0	13.0
II Claims Processed										
1) Returned	18,096	25,954	1,508.0	2,162.9	72.4	103.8	14.5	20.4	17.5	43.4
2) Rejected	15,230	9,095	1,269.2	757.9	60.9	36.4	12.2	7.1	(21.6)	(40.3)
3) Review committee	181	528	15.1	44.0	.7	2.1	.1	.4	—	191.7
4) Paid										
(a) Inpt.-Outpt.	76,299	69,501	6,358.3	5,791.7	305.2	278.0	61.0	54.5	5.9	(8.9)
(b) Drugs—Vendor	2,159	1,272								
Reimbursement	11,950	10.050	1,175.8	943.5	56.4	45.3	11.3	8.9	17.5	(19.7)
(c) Handicap	150	128	12.5	10.7	.6	.5	.1	—	—	(14.7)
(d) Applied for ded.	967	11,129	80.6	927.4	3.9	44.5	.8	8.7	—	1056.3**
Subtotal paid claims	91,525	92,080	7,627.1	7,673.3	366.1	368.3	73.2	72.1	8.6	.6
Total claims processed	125,032*	127.657	10,419.3	10,638.1	500.2	510.6	100.0	100.0	4.8	2.1
III Difference II-I	4,721	(8,305)	393.4	(629.1)	18.9	(33.3)	—	—	—	—
IV Funds Disbursed										
1) Regular (Inpt/Outpt)	6,960,943.86	6,450,514.58	580,078.66	537,542.88	27,843.77	25,802.06	91.7	92.5	1.5	(7.4)
2) Reimb. drug	532,790.21	450,340.29	44,399.18	37,528.36	2,131.16	1,801.36	7.0	6.5	27.8	(15.5)
3) Vendor Drugs	9,533.26	5,597.52	794.44	466.46	34.13	22.39	.1	.1	—	(41.3)
4) Handicap	85,906.80	69,476.65	7,158.90	5,789.72	343.63	277.91	1.2	.9	(10.8)	(19.1)
Total	7,589,174.13	6,975,929.04	632,431.18	581,327.42	30,356.69	27,903.72	100.0	100.0	2.8	(8.1)

	1976	*1977*
V Average Disbursements Per Claims		
1) Regular (Inpt/Outpt)	91.23	92.81
2) Drugs—Reimbursement	44.58	44.81
3) Drugs—Vendor	4.42	4.40
4) Handicap	572.71	542.79
Overall average	60.70	54.65

* It is possible to process more than received because of re-processing returned claims and the separation of claims into two or more different claims to meet processing requirements.

** Reason for high percentage jump is because program of running "accumulations for deductibles" through with the paid claims rather than rejecting them was begun 12/76, so only one month's worth of claims were reflected in this way in 1976.

GEORGIA CANCER REGISTRY

The Georgia Cancer Registry was refunded by the Department of Human Resources in July, 1977. This funding was for a total of $69,500.00 contracted in six month increments for a period of one year.

Currently, there are twenty-four Georgia hospitals participating in the program. Six of these are located in the metro-area, while the remaining eighteen facilities are located in outlying districts. In the past year three hospitals have joined the program and one facility has withdrawn. This withdrawal was as a result of that hospital closing its tumor registry for an indefinite period of time.

The data base presently contains information on 67,968 cases. This figure reflects most of the 1976 cases with analytical data going back to 1967. The base also contains non-analytical data on a number of cases treated as far back as 1940. This data is available in report form to Georgia physicians and hospitals. Many types of informative reports have been produced using numerous report parameters.

Consultation visits are made to each participating hospital several times per year. These site visits are advantageous in training hospital tumor registry personnel and in clarifying problem areas both in office procedure and in valid documentation on the abstract and follow-up forms.

The Georgia Cancer Registry, along with the Georgia Tumor Registrars' Association and the American Cancer Society, Georgia Division, participated in an educational seminar for Georgia hospital tumor registry staff members in October, 1977. A total of forty-six people from twenty-four hospital-based and central tumor registries attended. In Georgia, these educational seminars are the primary source of continuing education for the tumor registrar.

MAG SERVICES, INC.

The print shop is in full operation. Our November and December work load was unusually heavy as the result of the large number of orders received for prescription blanks.

Our print shop continues to function, and while quality and amount of work is improving, we are still not operating at a profit. We have served 1,055 of our members, and 250 of these have come back for repeat business. In addition, we have done $41,754.00 in-house printing for the Medical Association, Research & Development, Georgia Medical Care Foundation, GaMPAC, and CHAMPUS.

We solicit your orders for stationery, prescription pads, etc. We offer fine quality work on short notice at a considerable saving.

INFORMATION SYSTEMS

The information Systems function at MAG was begun in 1974 to meet the needs of the EMCRO project. Since then it has grown to include a staff of four computer professionals and now provides data processing services to virtually every department of the Association and the Georgia Medical Care Foundation. Many functions previously performed by outside service organizations or done by hand are now "on the computer," resulting in a saving in cost, an increase in efficiency, or both.

A Datapoint 5500 small business computer leased by MAG and located in the Headquarters Building is used for the bulk of the processing. This arrangement allows the various departments within MAG to have their own computer terminals, and protects the confidentiality of the information being processed by keeping it entirely within the MAG building. An agreement with Emory University allows MAG to purchase computer time from them at a very low cost when the resources of a large scale computer are needed to process non-confidential data.

The computer is used to process payrolls for both MAG and the Foundation. The MAG Membership Information System, which includes membership records, dues accounting, and mailing-list preparation is "on-line" to the computer. The Georgia Cancer Registry, which MAG operates under contract to the state, uses the computer to maintain an index of tumor patients; this index is not only a valuable research tool, it also helps participating hospitals meet the American College of Surgeons certification requirements. The Foundation maintains a data base on over 8,000 providers of health care and nearly 70,000 recipients using the computer. Because MAG has control over the computer, the confidentiality of this information can be assured.

Many of the things done with the computer would be impossible or impractical without automatic data processing. For example, MAG's sliding dues scale for new and senior members could probably not be administered effectively by hand. The Foundation's computerized general ledger furnishes management with much more information than would be practical with a manual system, and does it faster.

Until March of 1978, MAG's Information Systems staff provided computer support for the CHAMPUS program in Georgia. The CHAMPUS contract is now held by the Mutual of Omaha Insurance Company. The loss of this contract has had a severe financial impact on the Association. At their January meeting, the Board of Directors approved supplemental funding to keep the computer in operation for the remainder of this fiscal year. The Finance Committee of the Board of Directors has prepared a recommendation to the House to allow operations to continue next year.

If the House approves the continuation of the computer operation, several new areas will receive computer support in the coming year. A study is under way to provide computer assistance in MAG's Physician Placement Service, providing better and faster responses than are possible by hand. The accounts payable function at both MAG and the Foundation will be computerized, resulting in better cash flow management and direct dollar savings due to better use of funds. The accounts payable system will be integrated with the existing general ledger system for full management control. In the Foundation area, the power of the computer will be used to assist in the operation of the nursing home bed registry and nursing home certification programs. Finally, if a PSRO is established in Georgia, the Board of Directors may instruct MAG's staff to bid to furnish the necessary data processing resources. This last is especially important since it would mean that potentially sensitive data relating to peer review would be under the control of MAG rather than some other organization.

I wish to thank the House of Delegates for allowing me to be secretary of MAG for the past six years. I have enjoyed the association with the staff and each of you and

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ycolog Cream (Nystatin — Neomycin Sulfote — Gramicidin — Triam-nolone Acetonide Cream) provides 100,000 units nystatin, neomycin lfote equivalent to 2.5 mg. neomycin base, 0.25 mg. gromicidin, and mg. triomcinolone ocetonide (0.1%) per gram in an aqueous per-med vanishing creom bose.

NDICATIONS: Based on a review of this preporotion by the No-ionol Academy of Sciences—Notionol Research Council and/or other information, FDA hos classified the indicotions os follows: **Possibly effective:** In cutaneous condidiasis; superficiol bocteriol nfections; the following conditions when complicated by candidal nd/or bocteriol infection: atopic, eczemotoid, stasis, nummular, ontact, or seborrheic dermotitis, neurodermotitis, and dermatitis enenata; infontile eczemo; lichen simplex chronicus; and pruritus ni ond pruritus vulvoe.

Finol classificotion of the less-than-effective indications requires urther investigotion.

ONTRAINDICATIONS: Virol diseoses of the skin (such as vaccinia nd voricello); fungol lesions of the skin except candidiasis; history hypersensitivity to any product component. Not intended for oph-olmic use; should not be applied in the external ouditory conol of atients with perforoted eordrums; should not be used when circula-on is morkedly impaired.

ARNINGS: Because of the potential hozord of nephrotoxicity and otoxicity, prolonged use or use of large amounts of this product ould be ovoided in the treotment of skin infections following ex-nsive burns, trophic ulceration, and other conditions where absorp-on of neomycin is possible.

sage in Pregnancy: Although topicol steroids have not been re-orted to have an adverse effect on the fetus, the safety of topicol steroids during pregnoncy hos not been absolutely estoblished therefore, do not use extensively on pregnant potients, in lorg omounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other thon candida). Should superinfec tion due to nonsusceptible organisms occur, administer suitable concomitant antimicrobiol therapy; if favorable response is not prompt discontinue the preparation until odequate control by other anti infectives is effected. If extensive oreas are treated or if the occlusive technique is used, the possibility exists of increosed systemic absorp tion of the corticosteroid; suitable precautions should be token. I irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reoctions to topical use of gramicidir are rore. Hypersensitivity to nystotin is extremely uncommon. Hyper sensitivity to neomycin has been reported ond articles in the curren medical literature indicote an increose in its prevolence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burn ing sensotions, itching, irritotion, dryness, folliculitis, secondary infec tion, skin atrophy, striae, milioria, hypertrichosis, ocneform eruptions macerotion of the skin, and hypopigmentation. Contact sensitivity to c particular dressing material or adhesive may occur occasionally. Oto toxicity and nephrotoxicity hove been reported.

For full prescribing information, consult pockage insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also avail able in jors of 120 g. (4 oz.) for hospitol or institutional use only.

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look forward to serving MAG in the future in whatever capacity you wish.

REFERENCE COMMITTEE RECOMMENDATION:

The Report of the Secretary is an informational report describing the past year's activities of the various entities within the MAG, including CHAMPUS, MAG Foundation (Benevolent), Headquarters Office, The Georgia Cancer Registry, MAG Services, Inc., and the Information Systems.

RECOMMENDATION:

Mr. Speaker, your Reference Committee suggests that the Report of the Secretary be accepted and that the Secretary be commended for his effort on behalf of our Association.

HOUSE OF DELEGATES ACTION—Commended the Secretary and accepted his report.

RESOLUTION 2
MEDICAID FRAUD AND ABUSE AUDIT—NOVEMBER 1976

Joe L. Nettles, M.D.

WHEREAS, the results of the Medicaid Fraud and Abuse Audit done at the request of the Governor of the State of Georgia by the Department of HEW have not been published, and

WHEREAS, the results of the investigation might help to improve the quality of health care in this state, now THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia request from the Office of the Governor and the Department of HEW the results of the audit.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 2 asks that the Medical Association of Georgia request the results of the Fraud and Abuse Audit conducted of the Georgia Medicaid Program in November of 1976, from the Governor and the Department of Health, Education and Welfare.

Reference Committee B heard information that this audit was never completed by the federal government and, therefore, that such information would not be forthcoming. Moreover, your Reference Committee was informed that the President of the Medical Association of Georgia has already taken the action requested by this Resolution.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 2 be filed.

HOUSE OF DELEGATES ACTION—Resolution 2 Filed.

COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D., Chairman

The Access to Health Care Committee had an active year with a meeting on Sunday, September 11, 1977, and Sunday, January 15, 1978. Together with the Southeastern Institute for Community Health of LaGrange, a physician recruitment prepractice seminar was held at Callaway Gardens, October 21-23, 1977. There was general agreement that this activity should be continued for at least one more year.

The Committee thanks Mr. Adam Jablonowski and Mr. Sherwood Williams for their able assistance in the activities. The Committee hopes that a start has been made toward relieving underserved areas of medical care in the State of Georgia.

The following recommendations are made to the House of Delegates at the next scheduled meeting:

RECOMMENDATIONS

1. Access to Health Care Committee pursue communications with other groups interested in physician placement in underserved areas. These groups would include, but not limited to HSA, Joint Advisory Board for Family Practice, State Medical Education Board, and National Health Service Corp. Participation in placement activities of these groups should be carried out by this committee.
2. The Committee recommends that the MAG Board of Directors through legislative activities support state funding for family practice programs in Georgia.
3. Realizing that there is presently a list of physicians interested in placement and communities interested in placing physicians, it is recommended that the staff study the feasibility of a placement bulletin or staff person to act as a placement coordinator and to check the possibility of coordinating the use of the computer in updating information in this placement bulletin. The Committee has already charged the administration of MAG to look into this matter and come back with specific recommendations for mechanisms and financing.
4. It is recommended that consideration be given to reevaluation of the state scholarship program and placement efforts associated with this program in order to make it more efficient.
5. It is recommended that communities be acquainted with the criteria by which a community is judged by those physicians seeking placement. This information is available through the placement service of the AMA and should be distributed to interested communities. The committee felt that it was not necessarily its place to decide whether or not a community should have a physician believing that the law of supply and demand may operate in this area.
6. Responding to 1977 House Action Res. 25, the committee recommends that when utilizing salaried physicians, a hospital should be extremely careful to preserve the patient's right to choose the physician who will treat him and salaried emergency room physicians should contain their activities to the emergency room and not be permitted to admit patients.

REFERENCE COMMITTEE RECOMMENDATION:

This report included information concerning the activities of this Committee over the past year.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Recommendations 1, 2, 3 and 5 of the Committee on Access to Health Care be adopted.

With regard to Recommendation 4, your Reference

REFERENCE COMMITTEE B

Committee suggests the adoption of this recommendation with the addition of the following phrase, "And that the Medical Association of Georgia convey these feelings to the State Medical Education Board."

With regard to Recommendation 6, your Reference Committee recommends that this recommendation be amended by deletion and substitution to read as follows: "The Committee recommends that when utilizing salaried physicians, the hospital should be extremely careful to preserve the patient's right to choose the physician who will treat him and that salaried emergency room physicians should contain their activities to the emergency room and not be permitted to admit patients in their own name."

HOUSE OF DELEGATES ACTION—Adopted Recommendations 1, 2, 3 and 5 of the Committee on Access to Health Care. Adopted Recommendation 4, with the additional phraseology suggested by the Reference Committee. Adopted Recommendation 6 as amended by the Reference Committee, and as further amended on the floor of the House so that the adopted Recommendation 6 would read, "The Committee recommends that when utilizing hospital-employed fee-for-service or salaried emergency room physicians, the hospital should always preserve the patient's right to choose the physician who will treat him and that hospital-employed fee-for-service or salaried emergency room physicians should contain their activities to the emergency room and not be permitted to admit patients in their own name."

RESOLUTION 27
MISREPRESENTATION BY THIRD-PARTY CARRIERS

DeKalb Medical Society

WHEREAS, the medical profession is being increasingly harassed by scurrilous statements, innuendo, subtle suggestion, and blatant misrepresentation of facts, and

WHEREAS, our patients are being supplied such propaganda by third-party carriers, in regard to fees, and as we usually have no knowledge of this, and no opportunity for explanation, and

WHEREAS, these accusations of overcharging and failure to adhere to usual and customary fees, are not based on fact, but on complex formulae, usually out of date and out of touch with reality, and

WHEREAS, these statements by third-party carriers, made to patients, are direct, specific, unyielding, and imply unethical behavior, and

WHEREAS, this form of subtle propaganda is persuasive to public opinion and damaging to the overall image of our profession, NOW THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia mount an all-out effort through our congressional delegation to explain the harm being done by these measures, and require that the procedures be stopped, and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia vigorously inform third-party carriers as to our feelings on this matter and direct that these procedures be stopped, AND BE IT FURTHER

RESOLVED, that the Medical Association of Georgia mount a campaign to inform the public of the inaccuracies and misinformation being represented to them and attempt to restore the public confidence and trust in our profession which has been damaged by the statements made by third-party carriers.

REFERENCE COMMITTEE RECOMMENDATION:

Resolution 27 is a request that the Medical Association of Georgia make various parties aware of the problems encountered by the medical profession in dealing with the third party carriers. In considering this subject, your Reference Committee heard considerable discussion of a wide variety of problems encountered by physicians in dealing with various private and federal health insurance programs in Georgia. After considering these various items of testimony, your Reference Committee would suggest the following substitute Resolution 27:

"RESOLVED, that the Medical Association of Georgia mount an all-out effort to inform our congressional delegation, various certain third-party carriers, and the public at large, of the inaccuracies and misinformation being represented to them by certain third party payors concerning the extent of health insurance coverage and that, through this effort, an attempt should be made to restore the public confidence and trust in our profession which has been so badly damaged by these misrepresentations made by the third party carriers."

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests adoption of the substitute Resolution 27.

HOUSE OF DELEGATES ACTION—Adopted substitute Resolution 27 as written by the Reference Committee.

RESOLUTION 7
PEER REVIEW

Ogeechee River Medical Society

Be it known that the Ogeechee River Medical Society supports the following resolution as proposed:

WHEREAS, the MAG House of Delegates in April 1976 adopted a report of the Council (now Board of Directors) that stated in part "that the Medical Association of Georgia endorses and supports only that medical peer review performed by private practicing physicians free to exercise their independent professional judgement at the time of the review and conducted within the established and recognized peer review system constituted by the Georgia Medical Care Foundation and the Metropolitan Atlanta Foundation for Medical Care," and,

WHEREAS, the physicians practicing in the Blue Cross-Blue Shield/Columbus area are desirous of having the determination of the medical appropriateness of their claims based on true peer review, now THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia advise Blue Cross-Blue Shield/Columbus of the strongly held desires of the physicians in their service area to have peer review of their services performed by the Georgia Medical Care Foundation, and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia strongly recommends to Blue Cross-Blue Shield/Columbus that it utilize the Georgia Medical Care Foun-

dation as its mechanism for peer review in the future.

REFERENCE COMMITTEE RECOMMENDATION:

This item deals with a prior position taken by the House of Delegates with regard to Peer Review in the state of Georgia and requests reiteration of that position with regard to Blue Cross-Blue Shield/Columbus.

In considering this item, the Reference Committee was very pleased to receive written communication from H. Hilt Hammett, M.D., Chairman of the Executive Committee of the Blue Cross-Blue Shield/Columbus expressing the intent of that organization to initiate discussions with the Georgia Medical Care Foundation concerning the items in this Resolution. It is the feeling of your Reference Committee that this represents a tremendous step forward and we express our hope that these talks are fruitful.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 7 be adopted.

HOUSE OF DELEGATES ACTION—Adopted Resolution 7.

RESOLUTION 13
UTILIZATION REVIEW PROCESS

F. William Dowda, M.D.

WHEREAS, the Georgia Medical Care Foundation and the Metro Foundation for Medical Care have established functional peer review organizations, and

WHEREAS, Blue Cross/Blue Shield of Atlanta have seen fit to establish a concurrent hospital review program outside of these two organizations.

NOW, THEREFORE, BE IT RESOLVED, that the MAG ask Blue Cross/Blue Shield of Atlanta to desist in this activity immediately, and BE IT FURTHER

RESOLVED, that if Blue Cross/Blue Shield of Atlanta persist in this activity outside the Foundation, MAG ask all of its members not to cooperate in this utilization review process.

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution deals with the performance of concurrent hospital utilization review by Blue Cross-Blue Shield/Atlanta.

Testimony heard by your Reference Committee concerning this item finally led us to the conclusion that this resolution does not address the problem as we perceive it, that being that physicians on medical staffs of hospitals are being placed in positions of performing fiscal review for private third-parties, rather than review for the appropriate necessary services rendered.

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 13 be not adopted, and that the following substitute Resolution be adopted:

"RESOLVED, that the Medical Association ask Blue Cross-Blue Shield/Atlanta to allow local hospitals to elect concurrent hospital utilization review under the full auspices of the Georgia Medical Care Foundation and the Metropolitan Atlanta Foundation for Medical Care as an alternative to its present concurrent hospital utilization review program."

REFERENCE COMMITTEE B

HOUSE OF DELEGATES ACTION—Voted that Resolution 13 be not adopted and that the substitute resolution written by the Reference Committee be adopted in lieu thereof.

RESOLUTION 14
FEDERAL EMPLOYEES INSURANCE PROGRAM

F. William Dowda, M.D.

WHEREAS, there is a strong belief that the Federal Employee Insurance program will be grandfathered in under National Health Insurance, and,

WHEREAS, the AAFMC is currently attempting to qualify a network in Florida, Alaska, Colorado and several other states, and,

WHEREAS, this program has many enrollees in Georgia,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of MAG instruct the Georgia Medical Care Foundation to seek to become qualified for this program both in the administration of it as well as in its peer review aspect.

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution requests that the Georgia Medical Care Foundation be directed to become qualified as administrator of the Federal Employees Insurance Program in the State of Georgia.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 14 be adopted.

HOUSE OF DELEGATES ACTION—Delegate Charles Todd moved to amend Resolution 14 by substitution to it, "RESOLVED, that the Board of Directors of the Georgia Medical Care Foundation investigate the possibility of becoming involved in the FEP program of the American Association of Foundations for Medical Care, and present their findings to the MAG Board of Directors, who are hereby directed to authorize the Georgia Medical Care Foundation to proceed." This substitute was adopted.

RESOLUTION 15
PEER REVIEW NETWORK

F. William Dowda, M.D.

WHEREAS, the Peer Review Network of the AAFMC program continues to ferment, and

WHEREAS, it offers good M.D. industry contact,

THEREFORE BE IT RESOLVED, that the MAG House of Delegates instruct the Georgia Medical Care Foundation to seek to involve itself with the Peer Review Network of AAFMC.

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution deals with the Peer Review Network of the American Association of Foundations for Medical Care and Georgia's participation in that network.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 15 be adopted.

HOUSE OF DELEGATES ACTION—Delegate Richard C. Mattison moved to amend the recommendation of the Reference Committee to, "Refer Resolution 15 to the MAG Board of Directors for further study." This was adopted.



Chairman Alexander H. S. Weaver presents the Reference Committee's report.

RESOLUTION 16
HMO-INDEPENDENT PRACTICE ASSOCIATION

F. William Dowda, M.D.

WHEREAS, it is the current feeling that the HMO-IPA combination offer medicine a way of organizing and negotiating for working conditions without the necessity of going the union route, and

WHEREAS, the HMO by law must have ⅓ of its directors from the public section, and

WHEREAS, the IPA may have an all M.D. Board of Directors,

NOW THEREFORE BE IT RESOLVED, that the MAG seek to establish a state-wide federally qualified HMO and to establish a network of IPA's around the state.

RESOLUTION 17
HEALTH MAINTENANCE ORGANIZATIONS—INDEPENDENT PRACTICE ASSOCIATION

F. William Dowda, M.D.

WHEREAS, the HMO-IPA activity represents the best way in which physicians may organize and protect themselves,

NOW, THEREFORE, BE IT RESOLVED, that the MAG House of Delegates go on record as favoring the HMO-IPA concept and be it

FURTHER RESOLVED that this House instruct MAG's delegates to the AMA to introduce at the next meeting of the AMA House a resolution calling for the AMA to seek to establish a network of HMO-IPAs throughout the United States.

REFERENCE COMMITTEE RECOMMENDATION:

These two Resolutions were considered together due to the similarity of their content. They suggest that the Medical Association of Georgia actively pursue the question of establishment of a statewide HMO in Georgia and/or go on record as favoring the establishment of HMOs and IPAs.

Mr. Speaker, your Reference Committee heard considerable testimony on both sides of these particular resolutions. In considering these items, it was pointed out that the establishment of HMOs involved a considerable risk on the part of the organization and should be addressed very slowly, if at all.

In hearing this testimony, your Reference Committee was able to ascertain that it was the intent of the author of these resolutions, primarily, to bring these items before the House of Delegates for their consideration. After thorough consideration of the testimony that was heard, it was the feeling of your Reference Committee that this primary intent of the author had been met through the introduction and consideration of these resolutions, and that there was no need at this time to take any further action.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 16 and Resolution 17 be not adopted.

HOUSE OF DELEGATES ACTION—Delegate F. William Dowda moved to amend the Reference Committee recommendation concerning Resolutions 16 and 17, by the addition of the following phraseology at the end of the Reference Committee recommendation, "and the subject matter be referred to the MAG Board of Directors for further study." The Dowda amendment passed, and the Reference Committee recommendation, as amended, was adopted.

RESOLUTION 4
CERTIFICATE OF NEED

DeKalb Medical Society

WHEREAS, the Attorney General of Georgia and several other states have felt that Certificate of Need legislation is unconstitutional in their state, and

WHEREAS, the very act of Certificate of Need violates the principles of private enterprise, and

WHEREAS, Certificate of Need legislation is being considered for physicians offices, and

WHEREAS, this concept removes local control and centralizes control in the office of HEW, and

WHEREAS, two separate studies ("Certificate of Need," Bicknell and Walsh, *New England Journal of Medicine*, May 15, 1975 and "The Impact of State Certificate of Need Laws on Health Care Costs and Utilization," Salkerer and Brice) have shown that Certificate of Need legislation will require the establishment of another bureaucracy that does not reduce the cost of medical care, THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia go on record as continuing its stand in opposition to Certificate of Need legislation, and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia vitally publicize this position through various levels of organized medicine, and BE IT FURTHER

RESOLVED, that the Governor of Georgia, the Honorable George Busbee, be requested to instruct the Attorney General of Georgia to file an Amicus Curiae brief in the case pending in the U.S. Supreme Court concerning the same principle that was ruled unconstitutional in North Carolina regarding the Certificate of Need position of PL 93-641.

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution deals with the constitutionality of Certificate of Need legislation and requests that the Medical Association of Georgia continue its opposition to this type of legislation.

Your Reference Committee heard no testimony in opposition to the items covered in Resolution 4, and it feels that they are still pertinent and need to be restated.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 4 be adopted.

HOUSE OF DELEGATES ACTION—Delegate James Kaufmann moved to amend the first RESOLVED OF Resolution 4 to read, "RESOLVED, that the Medical Association of Georgia go on record as continuing its stand in opposition to the concept of Certificate of Need." This was adopted. Resolution 4 was then adopted as amended.

COMMITTEE ON NURSING

J. Rhodes Haverty, M.D., Chairman

The Committee on Nursing continued to be active, meeting four times during the past year. All the meetings were held in conjunction with the Statewide Joint Practice Committee for Medicine and Nursing, consisting of the members of the Committee on Nursing and an equal number of nurses selected by the Georgia Nurses Association.

The nurse in the extended role was the principal subject of the committee's discussions. Examples of the extended role are the nurse practitioner, the nurse clinician, and the nurse mid-wife, all of whom may operate outside of the normal hospital or office pattern of nursing practice. The Committee was concerned with the issue of defining what the extended role of nursing can or should be as well as with the appropriate training and credentialing of these health professionals.

Realizing the physicians have many concerns about the expanded role for nurses, the Committee will devote its efforts to studying and clarifying the key issues involved. Along these lines, the Joint Practice Committee hopes to conduct educational programs on the expanded role nurse for hospital staffs and other groups of physicians and nurses requesting such education.

RECOMMENDATION

That the Committee on Nursing continue to serve as the physician component of the Statewide Joint Practice Committee on Medicine and Nursing, working to resolve problems and clarify issues related to the expanded role of nursing, and reporting its recommendations to the MAG Board of Directors.

REFERENCE COMMITTEE RECOMMENDATION:

This Report covered the activities of this Committee over the past year, in meeting with the Statewide Joint Practice Committee for Medicine and Nursing. The principal topic of consideration of the past year was the subject of the nurse in the extended role.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that the recommendation of the report of the Committee on Nursing be adopted.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Nursing.

REFERENCE COMMITTEE B

RESOLUTION 30
NURSE PRACTITIONERS

Worth County Medical Society

RESOLVED, that because nurse practitioners will be delivering health care to Georgia's citizens different from that of a Registered Professional Nurse that all nurse practitioners be certified and governed by the appropriate rules, regulations and laws of the Georgia Composite State Board of Medical Examiners.

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution deals with certification and regulation of "Nurse Practitioners" in Georgia.

Mr. Speaker, this Resolution, and others dealing with physician extenders, were considered at great length by your Reference Committee. Considerable discussion was heard from proponents and opponents of the concept of both "Nurse Practitioners" specifically, and Physician Extenders as a whole.

Among the most pertinent items in the testimony heard was an opinion by the chairman of the Legislative Committee, that a so-called nurse practitioner could not legally practice in the State of Georgia, and a subsequent suggestion that any effort on the part of the Medical Association of Georgia to deal with the question of separate licensing and/or certification of nurse practitioners at this time would only give more credence to the claims of this group for legitimacy. With this in mind, your Reference Committee finally concluded that it would be in the best interest of the Association not to accept this resolution at this time.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Resolution 30 be not adopted.

HOUSE OF DELEGATES ACTION—Delegate H. Gordon Davis moved a floor substitute for Resolution 30, which reads, "RESOLVED, that there needs to be further investigation of nurse practitioners, as nurses are practicing medicine in Georgia; and we

respectfully request that the MAG establish a committee to investigate the ramifications of this problem and that this committee report its findings to the Board of Directors.'' The substitute resolution was adopted.

COMMITTEE ON PHYSICIANS' ASSISTANTS

William J. Rawls, M.D., Chairman

The Committee, reconstituted after the 1977 MAG House of Delegates, has been active over the past year, holding three meetings.

The specific charge given to the Committee is to present information on the status of physicians' assistants (PAs) in Georgia to the 1978 House of Delegates. The information is as follows:

a) Number of PA schools: two—Medical College of Georgia and Emory.

b) Number of PA students: 128 (MCG 48, Emory 80).

c) Number of PAs graduating: 61 (MCG 23, Emory 38).

d) Projected enrollment in PA schools: 64 per year (MCG 24, Emory 40).

e) Projected need for PAs: This information is not available. In fact, it has not even been possible for a local Health Systems Agency to project the need for physicians. However, the two PA training programs have not encountered any great difficulty in placing their graduates.

f) Number of certified PAs: 306 as of January, 1978 (175 with permanent certification and 131 with temporary or ''grandfather clause'' certification).

It is the Committee's unanimous opinion that the concept of a physician extender in Georgia's current health care system is acceptable in principle, especially for rural or underserved areas. The term ''physician extender'' is a broad one, including PAs, nurse practitioners, emergency medical technicians, and even some experienced office nurses; but the Committee limited itself to consideration of the PA.

It is the Committee's opinion that in addition to provision of the information contained above in this report, a deeper study of the PA situation in Georgia should be part of its responsibility. As part of such study, the Committee invited to its meeting the directors of the two approved PA training programs in Georgia, who presented an overview of the training curricula as well as their philosophy of the PA's role in the delivery of health care. The Committee was impressed with the curriculum content and its clinical application, as expressed by the program directors. It is also the Committee's opinion that both programs emphasized the limitations of a PA's practice.

The Committee also studied the matter of PA certification, a system which in Georgia includes the two categories of ''permanent'' (graduate of an approved PA program) and ''temporary'' (informally trained or ''grandfather clause'') certification. The executive director of the National Commission on Certification of Physicians' Assistants was invited to a Committee meeting and explained the difference between national certification and state certification. To be certified in Georgia, a PA must be either a graduate of an approved training program or must take the national certification exam by December 31, 1979. To maintain national certification, a PA must pass the exam and also complete 100 hours of continuing education every two years.

One area which has not been completely resolved by the formal training programs and which has been a continuing concern to our Committee is the concept of supervision by the employing physician while the PA is directly involved in patient care (including situations in which the PA and his supervising physician are spatially separated). Other areas of concern are PA training, proper identification of the PA and explanation to patients of the PA's role and limitations, legal responsibility for care rendered by the PA, the prescribing of medications, proper credentialing of PAs by hospitals, and continuing education for the PA.

In the past, MAG members have expressed concern about abuses involving PAs, whether the abuses be on the part of the PA himself, his employing physician, or the government. The Committee urges anyone who has knowledge of such abuse to report it by sending a written complaint to the Composite State Board of Medical Examiners. Two members of the Board will review the complaint to determine if an investigation and hearing are in order. According to the Board's interpretation of a 1977 amendment to the Medical Practice Act, any person reporting such abuse or testifying to the Board enjoys the same immunity from civil and criminal liability as for reporting abuses by physicians.

As the Committee learned more about PAs and their role, it became apparent that it lacked sufficient guidance from the present Georgia law governing PAs on the matter of supervision of PAs. It also felt that this lack of clarity was generally shared by physicians practicing in the state. An educational program might be designed to better inform physicians, PAs, and, in some instances, patients of the proper functions and limitations of the PA.

RECOMMENDATIONS

1. That the MAG at this time is not yet prepared to formally endorse the entire PA concept, since there is need for further study and clarification.

2. That the Committee on Physicians' Assistants be continued for the purposes of

(a) informing the MAG membership about the proper utilization of PAs according to the current Georgia law governing PAs,

(b) identifying areas of the PA law in need of clarification and making appropriate recommendations to the MAG Committee on Legislation for revising the law, and

(c) serving as a liaison between organized physician and PA groups.

REFERENCE COMMITTEE RECOMMENDATION:

This Report, again, covers the activities of this Committee over the past year. It gives specific figures, citing the increase in scope of PA educational activities, which the House may find of interest:

A) Number of PA schools: Two (Medical College of Georgia and Emory).

B) Number of PA students: 128 (MCG 48, Emory 80).

C) Number of PAs graduating: 61 (MCG 23, Emory 38)

D) Projected enrollment in PA schools: 64 per year (MCG 24, Emory 40).

E) Projected need for PAs: This information is not available. In fact, it has not even been possible for a local Health Systems Agency to project the need for physicians. However, the two PA training programs have not encountered any great difficulties in placing their graduates.

F) Number of certified PAs: 306 as of January, 1978 (175 with permanent certification and 131 with temporary or "grandfather clause" certification).

Further, this report reviewed the matter of PA certification, supervision of PAs by physicians, and suggests that the Association would benefit from a deeper study of the PA situation in Georgia.

Again, as with nurse practitioners, your Reference Committee heard substantial amounts of testimony from both proponents and opponents of the physician assistant concept. The Committee was particularly distressed to learn that there is no information available projecting the need for physicians assistants in the state of Georgia and does feel that this entire subject is one which merits continued attention of the Association.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that Recommendation 1 of the Committee on Physicians Assistants be not adopted, and that the following substitute recommendation be adopted:

The Medical Association of Georgia recommends to those currently involved in training and certifying physicians assistants in the State of Georgia that, until the need for more physicians assistants can be documented, the training and certification of Physicians Assistants in Georgia be terminated and that current training programs be phased out as current training cycles end.

With regard to Recommendation 2 of the Report of the Committee on Physicians Assistants, Mr. Speaker, your Reference Committee suggests that this Recommendation be adopted.

HOUSE OF DELEGATES ACTION—Voted to adopt the Reference Committee's substitute for Recommendation 1, and voted to adopt Recommendation 2 of the Report of the Committee on Physicians' Assistants.

RESOLUTION 23
DEFINITION OF SUPERVISION OF PHYSICIAN EXTENDERS

Cobb County Medical Society

WHEREAS, the definition of "direct personal supervision" in the Physician's Assistant Act of the State of Georgia is not adequate, and

WHEREAS, there is much latitude for personal interpretation of the term adequate supervision, and

WHEREAS, some of the functions of physician extenders may be construed as the actual practice of medicine, and

WHEREAS, there is general confusion, nationwide, regarding the role of physician extenders, now THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia accept and promulgate the definition of direct personal supervision as established by the Georgia Academy of Family Physicians as stated below:

"Direct personal supervision is defined as being in the physical presence of the certifying physician or his covering physician/designee on a daily basis," and BE IT FURTHER

RESOLVED, that the Medical Association of Georgia recommend to the Georgia Composite State Board of Medical Examiners that nurse practitioners/nurse midwives fall under this definition when those nurses are acting as a physician extender.

REFERENCE COMMITTEE B

REFERENCE COMMITTEE RECOMMENDATION:

This Resolution deals with what constitutes direct personal supervision of a physician extender as contemplated in the Georgia Physician's Assistant Act.

In considering this resolution, your Reference Committee took into account its suggestion to you with regard to Resolution 30 (nurse practitioners) and the question of what would indeed constitute sufficient personal supervision of a physician extender. Again, there was considerable discussion of this item by a number of interested parties and your Reference Committee is pleased to make the following recommendations:

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests that the first "RESOLVED" of the Resolution 23 be not adopted and the following substitute Resolution be adopted in its stead:

"RESOLVED, that the Medical Association of Georgia accept and promulgate the following definition of direct personal supervision: Direct personal supervision is defined as being in the physical presence of the responsible physician or his covering physician designee on a daily basis."

With regard to the second "RESOLVED" of Resolution 23, in keeping with the prior recommendation of your Reference Committee with regard to "nurse practitioners," your Reference Committee suggests that this "RESOLVED" be not adopted.

HOUSE OF DELEGATES ACTION—Delegate Richard Cohen moved that the amended first RESOLVED of Resolution 23 be further amended by addition of the following to the Reference Committee recommendation, change the period to a comma, "and that all decisions regarding diagnosis and treatment must be after direct physical or phone contact with said responsible physician or his covering physician designee, and that MAG recommends the adoption of this definition by the Georgia Composite State Board of Medical Examiners." The Cohen amendment was adopted.

The first RESOLVED of Resolution 30 as amended by the Reference Committee and, as further amended on the floor, was then adopted. The House voted to not adopt the second RESOLVED of Resolution 23.

Chairman Weaver expressed his appreciation to the members of the Reference Committee for their time and effort and thanked those who appeared before the Committee to express their views.



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Members of Reference Committee F L. Austin Flint, Rupert H. Bramblett (vice chairman).

Report of Reference Committee F

WILLIAM E. HUGER, JR., M.D., Chairman

Chairman Huger reported that members of Reference Committee F met in Colony Hall at the Holiday Inn on Jekyll Island on Friday, April 14, 1978, and carefully considered all the items referred to the Committee. Members of the Reference Committee present included: William E. Huger Jr., M.D., Atlanta, Chairman; Rupert H. Bramblett, M.D., Cumming, Vice Chairman; L. Austin Flint, M.D., Canton; Cyler D. Garner, M.D., Gordon; William R. Hardcastle, M.D., Tucker; and Stuart H. Prather, M.D., Augusta.

OFFICE OF THE PRESIDENT

Milton I. Johnson, M.D., President

The saddest duty that has befallen me is to become president because of Bob Perry's death. He was a unique man who has left his mark and a trail for us to try to follow.

I take this opportunity to publicly express my thanks for the kind, complimentary and encouraging communications of support which many of our members have expressed.

In these brief months, the manifold responsibilities of the office of president have become indelibly apparent. There are almost daily problems which require decision and action.

This has been a year of change in the personnel in our administrative staff. We have hired some good replacements and are searching for others.

We have also lost the contract to administer the CHAMPUS Program. I think we did a good job of which we can be proud. This loss of revenue is going to cause some adjustment and realignment, but our financial position is stable.

At this point, our legislative program is effective, but we must continue to improve our rapport with our legislators. I think we have an excellent team to continue to produce positive results.

Colleagues, we must elevate ourselves above personal considerations and continue to fight and provide our patients with quality medical care. We must look at the short term and the long term effects of our actions. We must not practice "situation ethics."

We should adopt as our credo the fact that there is no right way to do a wrong thing, no correct way to do an incorrect thing, no honest way to do a dishonest thing, and no honorable way to do a dishonorable thing.

Serving as your president is one of the greatest honors that can come to a physician. I hope that my duties have been discharged in a manner that will merit your confidence and respect.

The office of president is so time consuming that we must face up to the fact that, if the president is not compensated for his time, the time will soon come when only a small percentage of our members can afford to serve.

RECOMMENDATIONS

1. I would recommend that the president be given a stipend of $350.00 per day for the time actually spent away from his practice, in addition to the present travel allowance.

2. Consideration should also be given for compensating the secretary for his many services in a more appropriate manner than a stipend of $100.00 per month.

This would be an investment in the stability and strength of our organization.

REFERENCE COMMITTEE RECOMMENDATION:

RECOMMENDATION 1

Mr. Speaker, your Reference Committee heartily commends Dr. Milton I. Johnson for his service as

president and requests that this recommendation be amended to read, "to allow the President reimbursement up to $300.00 per day for any time away from his regular scheduled work day, except when the President is meeting with the Executive Committee, the Board of Directors, the Annual Session, and the Scientific Assembly (with an annual maximum reimbursement not to exceed $24,000.00).

Mr. Speaker, your Reference Committee advises that Recommendation 1 be adopted as amended.

RECOMMENDATION 2

Mr. Speaker, your Reference Committee agrees that the Compensation for the secretary should be increased, and requests that this recommendation be amended to read, "the salary of the secretary be increased to $200.00 per month."

Mr. Speaker, your Reference Committee advises that this recommendation be adopted as amended.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 of the Report of the president as amended by the Reference Committee. Adopted Recommendation 2 as amended by the Reference Committee.

COMMITTEE ON COST ACCOUNTABILITY

H. Duane Blair, M.D., Chairman

The Committee on Cost Accountability is charged to study health care costs in an effort to control their rise without reducing the quality of care available to patients; to interact with similar committees at the hospital and county medical society level in order to share information in controlling rising costs; and to make recommendations to the MAG Board of Directors or the House of Delegates to establish MAG policy positions on controlling rising costs of health care.

The Cost Accountability Committee last year, under the very capable leadership of Harrison Rogers, made a number of recommendations to the House of Delegates. Allow me to bring you up to date on some of the actions taken regarding those recommendations approved by the House.

We have urged that insurance companies eliminate first dollar coverage and institute the use of deductible and co-insurance. We have also urged that out-patient benefits should be expanded with consideration given to higher deductible and co-payment for in-patient care and that the concept of co-insurance and deductible should be extended to Medicaid and Medicare.

We have urged, through the Georgia Hospital Association, that the four recommendations approved last year by the House pertaining to hospitals be implemented. Those recommendations were:

1. Medical audit procedures should be upgraded with assurance that findings are brought to the attention of the medical staff for their consideration of changing hospital procedures as indicated.

2. Support restrictions on costly additional services such as private room and private nurse services by insurance carriers. Elimination of duplicate testing for admission to the hospital, extended care or nursing home facilities should be strongly encouraged rather than required, as is often the case in government programs.

3. Hospitals should be urged to consider introducing or expanding self-care by the patient, including self-medication, room care, and use of cafeteria facilities.

4. Hospital medical staffs should be encouraged to inform themselves about costs of medical care in their facilities. This might include:

a. Posting the charges for the 20 most common procedures performed in the hospital so that physicians will see the prices in a prominently placed display.

b. On a periodic basis listing on his chart the cost of services provided to the patient.

c. Sending a copy of the hospital bill to the patient's physician by the billing office.

d. Keeping the medical staff members informed on hospital costs such as lab procedures, X-rays, tests, etc.

e. Establishing a "Cost Control" Committee of the medical staff or assign this to an existing committee.

We have also asked the Georgia Medical Care Foundation, CHAMPUS, and MAG's Committee on Peer Review to seek to find methods of implementing the recommendations concerning medical audit procedures.

We have asked MAG's Committee on Medical Practice to find ways to implement recommendation number four under hospitals.

We have asked the presidents of each county medical society to encourage local physician involvement in health system agency activities through membership on task forces, committees and boards of directors to assure that the best interests of patients are considered in all HSA decisions.

There was one other recommendation of the Committee that the House approved but that has not been accomplished. The House approved supporting the establishment of community meetings on health care costs. Such meetings would be composed of representatives from labor, management, local county medical societies, hospitals, the media and consumer interest groups.

The Committee felt to kick off such community meetings, a statewide conference should be held first and invite along with the county medical society representatives, national representatives from those previously mentioned groups—labor, management, media, etc.

The statewide conference would be the model for subsequent community meetings back home. Your Committee chairman made the proposal before the February MAG Executive Committee. The Executive Committee felt that as such a meeting could not be held before the latter part of March, the proposal should come before the 1978 House of Delegates. This will appear later in this report as one of the Committee's recommendations.

Part of the Committee's charge is to interact with representatives from the hospitals and other groups to share information and study health care costs in an effort to control their rise.

To this end, MAG has joined with the Georgia Hospital Association and the Federation of Georgia Hospitals, Inc., to form a Joint Steering Committee for Georgia on Voluntary Cost Containment. The state committee met initially in January. MAG's three representatives are from the Cost Accountability Committee and in addition to myself include W. Dan Jordan, M.D., and William L. McDaniel, M.D.

The MAG Executive Committee in February allocated $1,000 to the State Steering Committee to be used to cover such expenses as postage, mailings, etc., and that the House in April consider the extent of MAG's future in-

volvement in such a Steering Committee. We will have a recommendation to follow on this matter.

To tell you a little more of the Steering Committee, it is part of Georgia's effort in response to the challenge from Congress, specifically from Rep. Dan Rostenkowski (D., Ill.), for a voluntary alternative to the Administration's proposed Hospital Cost Containment Act. Rep. Rostenkowski is Chairman of the House Ways and Means Subcommittee on Health.

It appears evident, at this point, that should a voluntary program to reduce the rate of increase of hospital costs not be successful, federal legislation will be imposed. The Administration, of course, has plans to impose a 9% cap on hospital revenue increases.

If there is anything we do not need, it is more federal regulations in the health care field. The rate of increase in hospital costs is currently estimated to be around 13.7%. We, through our voluntary efforts, are seeking to reduce that rate of increase by 2% next year and by another 2% the following year. This would bring us to approximately 9.7%, a rate of increase near that of the rest of the economy.

The alternative, whether we like it or not, is very clear. Either we, through our own efforts, bring down the rate of increase, or it will be mandated by the federal government.

We at MAG could choose to allow the hospitals to fight their own battle regarding the 9% cap and sever our participation on the State Joint Steering Committee for Georgia on Voluntary Cost Containment.

Again, should our voluntary efforts at reducing the rate of increase of hospital costs not be successful, federal legislation is waiting in the wings. Such federal legislation cannot help but affect every physician in the country and not just hospitals.

Again, whether we like it or not, we are on the list of defendants of those being held responsible for controlling health care costs.

RECOMMENDATIONS

In addition to pursuing the enactment and implementation of those recommendations made by the Cost Accountability Committee and approved by the 1977 House of Delegates, the Committee wishes to make the following recommendations:

1. That MAG support the concept of the Joint Steering Committee for Georgia on Voluntary Cost Containment and that the extent of support in staff and financial assistance be determined by the Board of Directors and/or the Executive Committee.
2. That although MAG will be providing staff assistance to the Joint Steering Committee, MAG and its members should retain the right to independent action on any recommendations which may ultimately come from the Georgia Steering Committee.
3. That MAG sponsor a statewide conference on controlling medical costs organized by the Cost Accountability Committee. Community meetings would follow using the statewide conference as a role model.

REFERENCE COMMITTEE RECOMMENDATION:

RECOMMENDATION 1

Mr. Speaker, your Reference Committee advises that MAG support the concept of the Joint Steering Committee on Voluntary Cost Containment and that the extent of support in staff and financial assistance be determined by the Executive Committee and/or the Board of Directors of MAG.

Mr. Speaker, your Reference Committee advises that Recommendation 1 be adopted.

REFERENCE COMMITTEE F

RECOMMENDATION 2

Mr. Speaker, your Reference Committee advises that MAG and its members retain their right to independent action on any recommendations coming from the Georgia Steering Committee.

Mr. Speaker, your Reference Committee advises that Recommendation 2 be adopted.

RECOMMENDATION 3

Mr. Speaker, your Reference Committee agrees that MAG sponsor a statewide conference on controlling medical costs organized by the Cost Accountability Committee, and that community meetings follow using the statewide conference as a model.

Mr. Speaker, your Reference Committee advises that Recommendation 3 be adopted.

HOUSE OF DELEGATES ACTION—Adopted Recommendations 1, 2, and 3 of the Report of the Committee on Cost Accountability.

REFERENCE COMMITTEE RECOMMENDATION:

Mr. Speaker, your Reference Committee has carefully considered all items in the budget and requests that the following amendments be made.

1. Section—Membership & Public Service

***Item*—Travel, Delegates and Alternates be reduced to $10,500.00, since Harrison L. Rogers, M.D., is on the Board of Trustees of the AMA and his expenses are paid by the AMA.**

***Item*—Prison Health Care be reduced to $8,436.00, to continue the Committee Program to 3/6/79 while partially funded by AMA.**

2. Section—Management Services, Business & Finance

***Item*—Personnel—add $1,200 to this figure to record the increase in the MAG Secretary's salary.**

***Item*—Xerox—Mr. Speaker, your Reference Committee believes it wise to purchase the Xerox 700 w/Auditron now at the Headquarters Office for $23,904.00. This purchase will result in a saving to MAG of $43,536.00 over the next ten years, the life of the machine. Substituting $2,136.00 (maintenance contract) instead of $7,200.00 (rental) opposite Xerox allows for the cost of twelve months service to this machine.**

3. Section—Association Activities—Under Annual Session

(Continued on page 563, following the budget)

BOARD OF DIRECTORS—BUDGET 1978-79

Joe C. Stubbs, M.D., Chairman

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-78 to 5-31-79*
INCOME		
Dues Collection		$ 900,000.00
Interest and AMA Refund		36,000.00
Parking		—
Journal Advertising		51,800.00
Newsletter		3,000.00
Rental Income		47,250.00
Journal Subscriptions		3,500.00
TOTAL INCOME		$1,041,550.00
EXPENSES		
Communications		$ 82,041.00
Continuing Medical Education		63,568.00
Governmental Affairs		42,262.00
Journal		91,853.00
Legal Costs and Retainers		43,680.00
Legislation		76,444.00
Membership and Public Services	$ 227,951.00	219,735.00
Management, Services, Business and Finance	63,554.00	59,690.00
Association Activities	106,292.00	130,292.00
Building Costs	155,140.00	171,875.00
Information Systems (Computer)	57,400.00	12,224.00
TOTAL EXPENSE	$1,010,185.00	$ 993,664.00
Excess of Income over Expenses	31,365.00	47,886.00
		$1,041,550.00
COMMUNICATIONS		
Personnel Salary		$ 27,212.00
Fringe Benefits		4,009.00
Payroll Taxes		
Insurance		
Retirement Benefit		
Telephone		13,000.00
Postage		18,000.00
Newsletter		4,200.00
Magnet Conference		4,000.00
Travel		1,920.00
Other Committee Costs		9,300.00
Constitution and By-Laws		400.00
TOTAL COMMUNICATION EXPENSE		$ 82,041.00
CONTINUING MEDICAL EDUCATION		
Personnel		$ 44,384.00
Fringe Benefits		6,194.00
Payroll Taxes		
Insurance		
Retirement Benefit		
Scientific Assembly		8,020.00
Education Committee		2,666.00
Travel		2,304.00
TOTAL CONTINUING MEDICAL EDUCATION		$ 63,568.00

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-78 to 5-31-79*
GOVERNMENTAL AFFAIRS		
Personnel		$ 34,782.00
Fringe Benefits		4,042.00
Payroll Taxes		
Insurance		
Retirement Benefit		
Research and Development		—
Travel		2,688.00
Liaison—Board of Human Resources		—
Composite Board of Medical Examiners		750.00
TOTAL GOVERNMENTAL AFFAIRS		$ 42,262.00
JOURNAL		
Personnel		$ 19,800.00
Fringe Benefits		4,541.00
Payroll Taxes		
Insurance		
Retirement Benefits		
Printing		46,000.00
Photo Processing		250.00
Engraving and Cuts		800.00
Advertising Promotion		3,500.00
Postage and Copyright		4,420.00
Subscriptions		262.00
Mailing Labels		—
Clipping Service		350.00
Artwork and Supplies		2,850.00
Data Processing Services		300.00
Travel		500.00
Advertising Commission		8,280.00
TOTAL JOURNAL EXPENSE		$ 91,853.00
RETAINERS		
Legal		$ 35,000.00
Insurance Actuary		7,000.00
Other		1,680.00
TOTAL RETAINERS		$ 43,680.00
LEGISLATION		
Personnel		$ 52,828.00
Fringe Benefits		7,819.00
Payroll Taxes		
Insurance		
Retirement Benefit		
State Legislative Expense		
National Legislative Expense		
Legislative Expense		9,689.00
Travel		4,608.00
Legislative Bulletin		1,500.00
TOTAL LEGISLATION EXPENSE		$ 76,444.00
MEMBERSHIP AND PUBLIC SERVICE		
Personnel		$ 61,820.00
Fringe Benefits		9,877.00
Payroll Taxes		
Insurance		
Retirement Benefits		

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-78 to 5-31-79*
WATS Line		4,700.00
Auxiliary—Health Careers		17,400.00
Roster		8,000.00
Travel—President		4,900.00
Travel—President Elect		2,100.00
Travel—Past President		2,100.00
AMA Costs:		
Caucus Breakfast		1,400.00
MAG Headquarters Suite		2,200.00
Southeastern Hospitality Suite		1,300.00
Travel—Delegates and Alternates	$ 12,000.00	10,500.00
Travel—Officers		2,800.00
Interprofessional Council		125.00
AMSA to MAG Annual Session		300.00
AMSA Travel Cost		650.00
State Medical Education Luncheon		250.00
AMA Leadership Conference (2 MD's)		850.00
Disabled Doctors Program		55,650.00
Access to Health Care		2,057.00
Allied Health		5.00
Health Planning		830.00
Awards		1,200.00
Membership Insurance		388.00
Professional Liability Insurance		1,725.00
Laboratory Quality		500.00
Maternal and Infant Welfare		1,000.00
Medical Aspect of Sports		—
Occupational Health		—
Prison Health Care	15,152.00	8,436.00
GaMPAC		5,000.00
Travel		3,072.00
MAG Foundation		4,200.00
Cost Accountability		4,400.00
Medical Practice		—
Joint Hospital Survey		—
TOTAL MEMBERSHIP AND PUBLIC SERVICE	$ 227,951.00	$ 219,735.00
MANAGEMENT, SERVICES, BUSINESS AND FINANCE		
Personnel	$ 21,485.00	$ 22,685.00
Fringe Benefits		5,881.00
Payroll Taxes		
Insurance		
Retirement Benefit		
Dues and Subscriptions		1,538.00
Data Base Maintenance		7,114.00
Audit		4,200.00
Office Supplies		6,500.00
Travel		1,536.00
Sundry		300.00
Equipment Purchases		4,000.00
Xerox	7,200.00	2,136.00
Payroll Computer		3,000.00
Retirement Trust Fee		800.00
TOTAL MANAGEMENT SERVICES, BUSINESS AND FINANCE	$ 63,554.00	$ 59,690.00
INFORMATION SYSTEMS		
Computer	$ 57,400.00	$ 12,224.00

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-78 to 5-31-79*
ASSOCIATION ACTIVITIES		
Personnel		$ 58,236.00
Fringe Benefits		10,268.00
Board of Directors Contingent		10,000.00
Executive Committee Contingent		5,000.00
Executive Committee Discretionary		5,000.00
Payroll Taxes		
Insurance		
Retirement Benefits		
Executive Committee Travel		3,800.00
Staff Travel		2,688.00
Meetings		2,200.00
Annual Session		9,100.00
President's Contingency	—0—	24,000.00
TOTAL ASSOCIATION ACTIVITIES	$ 106,292.00	$ 130,292.00
BUILDING EXPENSE		
Personnel		$ 5,266.00
Fringe Benefits		940.00
Payroll Taxes		
Insurance		
Retirement Benefits		
Maintenance:		
Building		7,000.00
Equipment		2,800.00
Taxes—Assets		13,600.00
Janitorial Services		9,600.00
Utilities		21,600.00
Building Insurance and Membership Insurance		6,000.00
Depreciation:		
Building		15,500.00
Equipment	$ 6,000.00	22,735.00
Interest on Mortgage		19,450.00
Sinking Fund for Land Acquisition		47,000.00
Travel		384.00
Leasehold Improvements		—
Less Reimbursable Expense		--
TOTAL BUILDING EXPENSE	$ 155,140.00	$ 171,875.00

add "President's" Contingency $24,000.00. This is a new line item created by the President's recommendations.

4. Section—Information Systems—Computer—Mr. Speaker, your Reference Committee believes it wise to purchase the Computer for $71,723.00 now being rented for $44,676.00. Substitute $12,224.00 (secretary salary) for the $57,400.00 (rental fee) in this section.

5. Section—Building Expense—*Item*–Depreciation—Equipment—adjust this figure by adding $2,390.00 (10% of the purchase price of the Xerox) and increase this figure an additional $14,345.00 (20% of the purchase price of the Computer). The total for Depreciation—Equipment should now read $22,735.00 instead of $6,000.00.

Mr. Speaker, your Reference Committee advises adoption of the Budget as amended.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Board of Directors on the 1978-79 budget with the changes as recommended by the Reference Committee.

RESOLUTION 20
SUMMARY REPORT OF AMA COMMISSION ON COST OF MEDICAL CARE

Medical Association of Atlanta

WHEREAS, in April, 1976, the AMA appointed a 27-member Commission on the Cost of Medical Care, including representatives from government, labor unions,



Chairman William E. Huger presents the Reference Committee report.

prepaid cost plans, insurers, and some private practicing physicians, and

WHEREAS, this same commission issued a summary report of its findings in December, 1977, but the AMA Board of Trustees lobbied strongly against allowing this same report to be considered by the AMA House of Delegates, and

WHEREAS, this same summary report completely overlooked the single most influential factor (greater than 50%) in the escalation of medical care costs, namely, the federal government, and

WHEREAS, this same summary report failed completely in identifying the mechanism of control of medical costs that exists when the patient has the power to control the medical market place via direct billing, and

WHEREAS, this same summary report recommends "major changes in the American medical care system" via "a process of strengthening price consciousness combined with complementary regulatory schemes," and further states "it is necessary to instill alternative behavior in everyone,"

NOW, THEREFORE, BE IT RESOLVED, that the MAG House of Delegates in 1978 Annual Session rejects this summary report of the Commission on Cost of Medical Care as being unacceptable, as failing to note the monopolistic practices instituted by the federal government and certain insurers, and as promulgating dictatorial schemes via regulation, and BE IT FURTHER

RESOLVED, that MAG's AMA delegation be instructed to communicate the above resolved to the AMA House of Delegates in an appropriate resolution.

RESOLUTION 29
NATIONAL COMMISSION ON THE COST OF MEDICAL CARE

Jack Menendez, M.D.

WHEREAS, the AMA Board of Trustees in 1976 established a Commission to Study the Cost of Medical Care and spent $400,000 to develop the first summary report in December 1977, and

WHEREAS, the summary report makes it clear that the AMA Commission views the Medical Profession as no better than a public utility to be regulated, and

WHEREAS, the summary report gives impetus to the complete socialization of the medical profession, NOW, THEREFORE, BE IT

RESOLVED, that the Medical Association of Georgia go on record to reject the report, and the implications of the report and instruct its AMA Delegation to oppose adopting the report in its entirety or in any part.

REFERENCE COMMITTEE RECOMMENDATION:

Mr. Speaker, your Reference Committee has spent many hours reviewing the summary report of the National Commission on the Cost of Medical Care. Our review was carried out, not only recommendation by recommendation, but paragraph by paragraph in minute detail. We made every attempt to determine any and all elements of the report which we felt the physicians of Georgia could accept.

We could find only one recommendation with that characteristic.

Noting that we do agree with only Recommendation 29 of the summary report entitled, "Disciplinary Measures for Physicians," which reads as follows, "The Medical profession should strongly encourage increased efforts to develop effective means for dealing with those providers of medical services who are found to be abusing or defrauding the health care financing and delivery system."

We, therefore, advise that the MAG House of Delegates adopt Resolution 20 from MAA and Resolution 29 from Dr. Jack Menendez, amending both to read as follows:

"RESOLVED, that the MAG House of Delegates at its 1978 Annual Session hereby rejects the dominant philosophy of the summary report of the Commission on the Cost of Medical Care as unacceptable to the physicians of Georgia and herewith instructs its AMA Delegation to vigorously oppose adoption of the Report by the AMA, in its present form.

HOUSE OF DELEGATES ACTION—Delegate Dan Jordan moved to instruct the AMA Delegation to introduce a resolution to the AMA House of Delegates conveying the MAG's position on the matter of the summary report of the Commission on the Cost of Medical Care. This was adopted.

The House then voted to adopt in lieu of Resolutions 20 and 29, the substitute resolution recommended by the Reference Committee and further amended on the floor by the Jordan amendment.

Chairman Huger then thanked the members of the Reference Committee and all those who contributed their time and opinions to this deliberation.

Special Report: Internal Review Committee

(EDITORIAL NOTE: *It had been previously determined and announced by the Chair that the Committee on Internal Review would make their report directly to the House of Delegates, rather than through a Reference Committee.*)



Robert W. Oliver, Chairman of the Special Internal Review Committee, presents his Committee's report to the House.

INTERNAL REVIEW COMMITTEE

Robert W. Oliver Jr., M.D., Co-Chairman
Luther Thomas, M.D., Co-Chairman

The 1977 House of Delegates concurred with a recommendation of Reference Committee A "that a committee of the House be appointed by the speaker of the House of Delegates and the president of MAG and be charged with the task of performing an internal review followed by an external review similar to that done recently for the Georgia Medical Care Foundation by Dr. John McCain."

Your Committee consisting of six physicians from throughout the state has had difficulty arranging meetings that a majority of the members could attend. However, the Committee has met four times during the year and has been able to handle some of its business by telephone. The Committee was in full agreement that it would not direct its attention to organization and function as this had been done in some detail by the recently discontinued Committee on Organization and Function. The Committee feels that its purpose is that of internal assessment and evaluation of how well MAG functions as it is presently organized.

The information and concerns expressed before the Committee in Macon and additional testimony received by the Committee in writing was reviewed and discussed in some detail. The Committee feels that it should make an effort to determine if the rank and file membership of MAG shares the views and concern expressed by those who have voiced these complaints.

In order to do this the Committee has, with some difficulty, compiled a questionnaire to be sent to the MAG officers, directors, alternate directors, delegates, alternate delegates, component society presidents and component society executive secretaries. Hopefully, this questionnaire will be mailed out with the Delegate Handbooks. The Internal Review Committee will meet in open session on Friday, April 14 at Jekyll Island in a room to be announced later to receive and review the completed questionnaires and hear any further testimony that anyone may wish to give. The Committee will then make a recommendation to the reference committee assigned this report.

RECOMMENDATION

The Internal Review Committee, therefore, recommends that this report be assigned to a reference committee and that the Internal Review Committee be allowed to make its recommendation to the reference committee after its meeting on April 14.

COMMITTEE ON INTERNAL REVIEW SPECIAL REPORT

Robert W. Oliver Jr., M.D., Co-Chairman
Luther Thomas, M.D., Co-Chairman

Mr. Speaker and members of the House of Delegates:

The Ad Hoc Committee on Internal Review has met on four occasions during the past year, as well as on April 14 and 15 at this Annual Session. The Committee has received verbal and written testimony from elected officials of MAG and staff members, both of which are closely involved with the functioning of MAG, as well as from grass roots members of MAG.

The Committee did not direct its attention to matters of organization and function, as this has been done in some detail by the recently discontinued Committee on Organization and Function. However, the subject did come up for discussion on several occasions because there are still some feelings that MAG cannot function optimally as it is presently constituted.

The mandate given the Internal Review Committee was to perform an internal assessment and evaluation of how well MAG functions, as it is presently constituted. Your Committee is pleased to submit the following report:

(1) QUESTIONNAIRE

It was the opinion of the group that a larger sampling of input than just from the elected officials of MAG was desirable in an effort to assess the organization's effectiveness.

A questionnaire was mailed to the delegates, alternate delegates, county society presidents, MAG officers, directors, alternate directors, county society executive directors, and MAG staff. Four-hundred-eighty-nine questionnaires were mailed and 83 were returned. Conclusions were based on responses to questions that were developed by the Committee. There were some excellent ideas stated by individuals in their narrative replies.

There seemed to be a consensus that the MAG staff was responsive to the policies and directives of the Board of Directors and House of Delegates and that proceedings were accurately documented and instructions were clear. Responses indicated that appropriate authority is exercised by the officers and bodies of MAG. Most respon-

dents felt that MAG staff's morale was good and that turnover in staff was related to available jobs with higher pay and/or status. Many were uncertain in their opinion concerning an appropriate spokesman for MAG policy, but a large number felt that the President of MAG was the appropriate individual (as established in Bylaws, Chapter V, Section 3). There was endorsement of the loyalty and support of staff and the officers of MAG and there was no indication that feelings of any individual or group was not loyal for any reason. There was no indication that significant change in MAG location, organization, or selection of officers was needed or desired.

One of the main concerns expressed by the MAG members who responded to the questionnaire was that of communication between MAG and its members. The Committee feels that a strong medical association is directly dependent on a well-informed membership. The present efforts being made by staff and officials is commended and we urge that they be expanded. One suggestion is that the *Newsletter* be expanded to include current controversial issues rather than just completed business. Another suggestion is that a mechanism be established whereby those members who so desire may be placed on a mailing list to receive minutes of the meeting of the Executive Committee and the Board of Directors. It is also felt that a renewed effort should be made by MAG staff to encourage component medical society officials to relay information to their membership.

(2) INTERVIEW RESULTS

A number of problems were identified as a result of interviews with the functioning officials of the organization. These included:

1. Chain of command: Several indicated that problems arise when differing directions come from the President, Secretary, Speaker of the House, and Chairman of the Board, and the functions of MAG Executive Director is hampered by such confusion of command at times.

2. Most of those interviewed felt that the executive director at times did not delegate responsibility adequately; but many expressed the view that he was not allowed enough autonomy in order to carry this out effectively.

3. A systematic evaluation by the Executive Committee of the staff function, especially executive director, was thought to be needed by some interviewed. These individuals felt that an annual efficiency survey should be made by the Executive Committee and that, when appropriate, the Executive Director should be appointed for periods longer than the current one-year period.

4. Attitude toward MAG staff. The overwhelming majority of those interviewed indicated a strongly positive feeling with regard to the MAG staff. Specifically, with few exceptions, the officials who work with staff extensively offered the view that the present executive director presents a combination of long experience, dedication to the job, unswerving loyalty to the medical profession in general and the MAG in particular, which, together, make him an invaluable asset to it. While a number indicated that administrative and executive expertise is less than optimal at times, the dominant opinion, with few exceptions, was that of an overwhelming vote of confidence to the present executive director.

In addition, those interviewed indicated that recent staff problems have now been largely resolved with the replacement of a number of lesser executives. It was generally felt that a sound staff team is now functioning at MAG Headquarters. Investigation of the question of a high rate of staff turnover has yielded the view that most, if not all changes were the natural result of moving to higher paying positions, changing locations, and response to personal factors. It was felt that staff pay is as high as practicable now, and is competitive with other medical societies, although probably not with private industry.

5. Annual Session Business. Several expressed concerns about the amount of business and length of time allowed to handle this business at the Annual Session. This Committee was assured that the Annual Session Committee is seeking solutions to these problems. We wish them success and recommended that they be supported in their efforts.

(3) CONCLUSIONS

1. There is a high regard for, and a high level of confidence in, the elected officers and the staff personnel of MAG by the respondents to the questionnaire.

2. There is a strong feeling of approval for MAG staff, especially the executive director, on the part of the great majority of elected officials.

3. A clearer definition of the chain of command from the Executive Committee to the executive director seems desirable.

(4) RECOMMENDATIONS

1. It is suggested that the Executive Committee of the MAG conduct a formal annual proficiency review of the executive director and that the results be reported to the Board of Directors for appropriate action. If the action is favorable then it should be backed up by a vote of confidence and support.

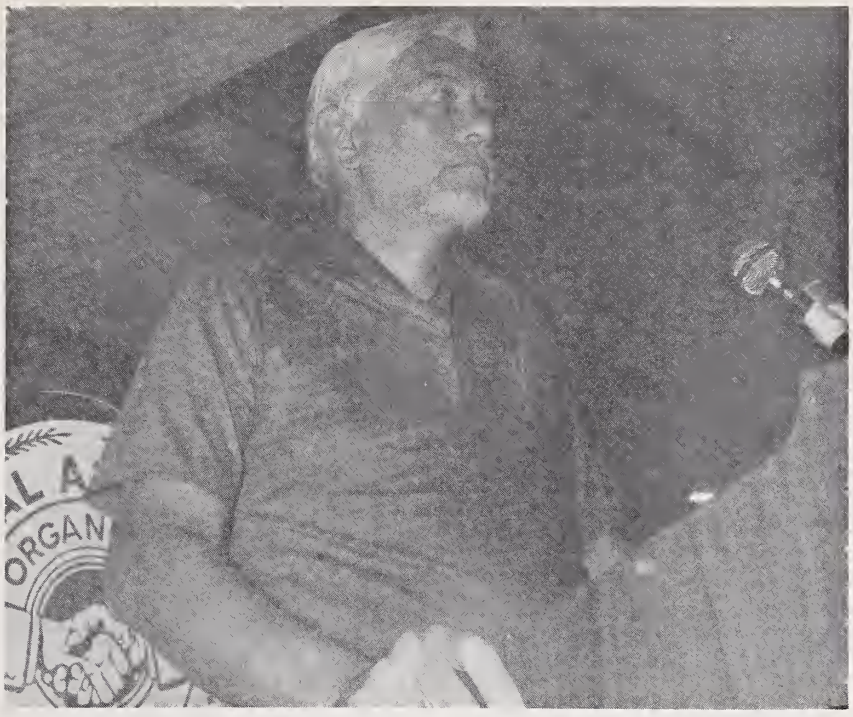
2. The Executive Committee should seek mechanisms for resolving disagreements among top officials in issuing directions to the MAG executive director. In this regard, the Committee points out that the Association's Bylaws (Chapter V, Section 3), clearly and unequivocally assign these responsibilities to the Executive Committee.

3. Your Internal Review Committee therefore recommends that this Committee be dissolved, as it feels that it has completed its assigned task and it feels that the solutions to the aforementioned problems can best be resolved through the existing mechanisms in MAG structure.

The Committee would like to thank all those who appeared before it, as well as those who answered the questionnaire. It would also like to thank the staff for its help and cooperation. I would like to personally thank the members of the Committee, Luther Thomas, M.D., Augusta; William C. Waters, M.D.; Atlanta, O. E. Ham Jr., M.D., Savannah; Roy Vandiver, M.D., Decatur; and Michel A. Glucksman, M.D., Brunswick.

HOUSE OF DELEGATES ACTION—Adopted Recommendations 1, 2 and 3 as presented in the special report of the Committee on Internal Review.

Delegate Jack Raines raised the question of an external review to be done during the 1978-79 year, as stipulated in the House of Delegates action of 1977. It was moved and seconded (Dowda/Glucksman) to not carry out an external review. This motion was adopted.



Chairman John P. Heard presents the Reference Committee's report.

Report of Reference Committee C

JOHN P. HEARD, M.D., Chairman
FLEMING L. JOLLEY, M.D., Vice-Chairman

Chairman Heard reported that Reference Committee B met in Colony Hall at the Holiday Inn on Jekyll Island on Friday, April 14, 1978, and considered all items referred to it. The members of the Reference Committee present were: John P. Heard, M.D., Decatur; Fleming L. Jolley, M.D., Atlanta; Charles Lanford, M.D., Macon; Edmund M. Molnar, M.D., Columbus; R. D. Walter, M.D., Calhoun; and Jimpsey B. Johnson, M.D., Augusta.

COMMITTEE ON CANCER

J. Moultrie Lee, M.D., Chairman

RECOMMENDATIONS 1 AND 4

The Committee has considered and acted on several cancer-related problems during the year.

The Board of Directors referred to the Committee the matter of the efficacy of Laetrile. This subject was reviewed extensively and the Committee recommended to the Board the following statement:

RESOLVED, that the Medical Association of Georgia continue to inform the public of the danger of delay in the diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective, and

BE IT FURTHER RESOLVED, that the Medical Association of Georgia inform the public that the safety and efficacy of amygdalin for the treatment of palliation of malignancies is unproved and that the use of amygdalin in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, in some cases for the profit of the unscrupulous;

NOW, THEREFORE, it is the position of the Medical Association of Georgia that Laetrile is a substance which has no proven value as a drug.

This was adopted by the MAG Board of Directors in September, 1977. In December, 1977, and January 1978, the Laetrile issue raised its ugly head again. The subject was discussed further at the Cancer Committee meeting in January, 1978.

RECOMMENDATION 1

Laetrile—Recommends adoption of the following:

"There is no recognized scientific evidence that Laetrile is effective as an anti-cancer treatment.

"Laetrile has been proven to be unsafe, and has been demonstrated to have definite toxic effects.

"The legalization of Laetrile will lead to the loss of life from failure to utilize effective means of cancer control.

"The true question is not freedom of choice but the protection of the public from a harmful and fraudulent product.

"THEREFORE, the Medical Association of Georgia is unequivocally opposed to any legislation legalizing Laetrile."

Dr. Thomas W. Phillips was appointed to represent the Medical Association of Georgia Cancer Committee in the hearings and investigation by the Georgia Legislature on the Laetrile matter.

The Board of Directors referred the matter of the Delaney Amendment to the Committee. This amendment was discussed at the January, 1978, Committee meeting. Note was taken of the fact that although the saccharin ban

had been lifted for 18 months, the Delaney Amendment was still in effect.

RECOMMENDATION 4

Delaney Amendment—Saccharin:

"RESOLVED, that the Medical Association of Georgia support the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal from the market.

"RESOLVED, that pending enactment of an acceptable amendment to the Food Additive Act, the Medical Association of Georgia support legislative or regulatory measures that will permit the continued marketing of saccharin as a food additive or an over-the-counter product with labeling warning of the potential increase in the incidence of cancer in animals and humans based on the currently available evidence."

The chairman wishes to extend his deep appreciation to the members of the Committee for their cooperation, aid, and interest throughout the past year.

RESOLUTION 8
LAETRILE, HOUSE BILL 1294

Ogeechee River Medical Society

WHEREAS, House Bill 1294 would permit the manufacture, sale, possession, use, and regulation of laetrile, under certain conditions, and

WHEREAS, laetrile would be classified as a drug to be controlled by the State Board of Pharmacy and could not be dispensed without a prescription and for which patients must be provided a written informed consent form.

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia go on record in opposition to HB 1294.

REFERENCE COMMITTEE RECOMMENDATION:

The Committee was instructed to consider Recommendations 1 and 4 of the Report of the Committee on Cancer. Recommendation 1 was discussed along with Resolution 8 which addressed itself to laetrile and the proposed defeat of House Bill 1294. House Bill 1294 died with adjournment of the recent legislative session and for this reason;

Mr. Speaker, your Reference Committee suggests Resolution 8 be filed.

There was not a great deal of open discussion concerning the subject of laetrile, but it was discussed in depth in the Executive Session of the Committee. The Committee feels the present legal status of laetrile in the State of Georgia should be explained. Federal law states it is illegal to transport laetrile across state lines for the purpose of resale. If an individual brings laetrile into Georgia for his personal use and asks a Georgia physician to administer laetrile to him, then it is legal for the physician to administer it to said patient, and only charge a fee for the administration of the substance.

Therefore, the use of laetrile is legal in the State of Georgia.

We reviewed the position taken by this Association through its Board of Directors in September, 1977, which is as follows:

"The Medical Association of Georgia should continue to inform the public of the dangers of delay in diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective. The Medical Association of Georgia should inform the public that the safety and efficacy of amygdalin for the treatment or palliation of malignancies is unproved and that the use of amygdalin in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill and in some cases for the profit of the unscrupulous. It is the position of the Medical Association of Georgia that laetrile is a substance which has no proven value as a drug."

RECOMMENDATION

Mr. Speaker, we feel that this still adequately expresses our opinion on this substance and therefore, your Reference Committee suggests that the Recommendation 1 of the Report of the Committee on Cancer be not adopted.

Recommendation 4, dealing with the Delaney Amendment—Saccharin: your Reference Committee heard discussion on this subject, and realized this was essentially the same resolution adopted by the AMA in 1977.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests adoption of Recommendation 4 of the Cancer Committee Report.

HOUSE OF DELEGATES ACTION—Delegate J. Moultrie Lee moved that the MAG position on Laetrile as adopted by the MAG Board of Directors in September 1977 be restated as follows: "The Medical Association of Georgia should continue to inform the public of the dangers of delay in diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective. The Medical Association of Georgia should inform the public that amygdalin has been proven to be unsafe and that the efficacy of amygdalin for the treatment or palliation of malignancies is unproven and that the use of amygdalin in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, and in some cases for the profit of the unscrupulous. It is the position of the Medical Association of Georgia that Laetrile is a substance which has no proven value as a drug." This motion was adopted in lieu of the recommendation of the Reference Committee.

Adopted Recommendation 4 of the Cancer Committee report.

COMMITTEE ON LEGISLATION

James A. Kaufmann, M.D., Chairman

The 1978 Georgia General Assembly ended following what the newspapers called a "quiet, non-productive session." For medicine, this was not the case. Your Committee on Legislation was more active this year than in the years past. Between the first day of the session, January 9, and the last day of the session, March 7, some 81 bills

were introduced and acted upon that dealt with the health care delivery system.

Several of these bills were sponsored by the Medical Association of Georgia. Others were introduced by other organizations. Some MAG supported and some MAG opposed. Hopefully, you will realize that in the two-month session, with 81 health bills being introduced, that it is the current trend of state legislatures to get more and more involved in the health care delivery system by acting upon bills dealing in numerous health fields. For this reason, it is incumbent upon each and every physician in Georgia to be aware of legislation dealing in all areas of health and become active in contacting your individual State Senator and State Representative regarding your feelings on each and every health issue introduced in the Georgia legislature. No one committee of MAG, no one staff person for MAG and no small handful of active MAG members can be expected to seek and obtain the outcome requested by MAG on 81 bills of interest to the medical profession each and every year. In order for the outcome of these bills to be what you and I would like, you *must* become active in the political arena.

I am proud to state that this year, as busy as it was, no bill which MAG opposed passed the Georgia legislature; however, several bills, which affect the health care of Georgia citizens, did not become law which MAG supported and therefore, will be reintroduced next year. Your help in the passage of these bills is imperative.

The following is a list of some of the bills introduced and acted upon this year:

H.B. 632 Consumers on the Board of Medical Examiners

This bill, as proposed, would add two consumers to the Composite State Board of Medical Examiners. Currently, said Board is made up of ten M.D.s and two osteopaths. H.B. 632 passed the House of Representatives and was defeated in the Senate Human Resources Committee. MAG took no active position.

H.B. 920 Certificate of Need

This, as proposed, would give Georgia a Certificate of Need law for all hospitals and related institutions promulgated under Public Law 93-641. H.B. 920 died in the House Health and Ecology Committee. MAG opposed.

H.B. 1231 Eye Banks

This bill, *as passed,* permits the removal of the cornea by medical examiners on the request of any eye bank in any case in which a patient is in need of corneal tissue or transplant when: (1) the decedent is under the jurisdiction of the medical examiner and an autopsy is required; (2) when no objection by the next of kin of the decedent for removal is known by the medical examiner; and (3) when the removal of the cornea does not interfere with the subsequent course of an investigation or autopsy. MAG supported.

H.B. 1240 Council on Maternal and Infant Health

This bill, *as passed,* expands the Council on Maternal and Infant Health by one. This one new person shall be a family practitioner. H.B. 1240 further states that there shall be equal representation of family practitioners, pediatricians and obstetricians. MAG supported.

H.B. 1241 Joint Advisory Board of Family Practice

This bill, *as passed,* alters the makeup of the Joint Advisory Board of Family Practice to include the Executive Committee of the Board of Directors of the Georgia Academy of Family Physicians. MAG supported.

REFERENCE COMMITTEE C

H.B. 1246 Confidential communications

As passed, this bill states no physician shall release any medical information regarding a patient to anyone without patient consent or under appropriate court order or subpoena. MAG supported.

H.B. 1258 Life Sustaining Procedures

This bill would provide the patients an opportunity to sign a "Directive to Physicians" indicating their desire for the physician not to employ life sustaining measures under certain conditions. H.B. 1258 passed the House of Representatives and was defeated in the Senate Human Resources Committee. MAG took no position.

H.B. 1294 & H.B. 1583 Laetrile

Both bills were put into study committee by the House Human Resources Committee. Both bills, as proposed, would permit the manufacture, sale, possession, use and regulation of laetrile approved under certain conditions. Laetrile would be classified as a drug and could not be dispensed without a prescription to patients by physicians. MAG followed this legislation closely.

H.B. 1307 Cruelty to Children

As passed, requires that any person convicted of cruelty to children causing the death of a child shall be punished by imprisonment for not less than five nor more than 20 years. MAG supported.

H.B. 1427 Arbitration

As passed, this bill permits voluntary binding arbitration for all groups (including physicians). This voluntary binding arbitration for medical malpractice is "after the fact" arbitration. MAG supported.

H.B. 1447 Commission on Physical Fitness

As passed, H.B. 1447 creates a State Commission on Physical Fitness for the purpose of protecting and improving the physical fitness of the residents of the State of Georgia. MAG supported.

H.B. 1526 Hearing Impairments: High Risk Infants

As passed, H.B. 1526 states that the Department of Human Resources shall develop guidelines for evaluation and follow-up procedures for the detection of hearing impairments in infants determined by DHR to be in those high risk categories in which the likelihood of such impairments is greatest. DHR shall develop rules and regulations to insure that all such high risk infants are evaluated within one year of their birth. MAG supported.

H.B. 1531 Clinical Laboratories

This bill would amend the current Georgia Clinical Laboratories Act by stating the Board shall promulgate rules and regulations which stipulate that in clinical laboratories in which no tissue pathology is performed, a medical technologist qualified as supervisor, may serve as technical and administrative director, if a physician licensed to practice medicine is responsible for clinical interpretation and consultation with physicians; providing that a medical techologist may serve as technical administrative director of one clinical laboratory only. Current law states that the director of clinical laboratories in Geor-

gia shall be licensed medical doctors. H.B. 1531 was defeated by the House Health and Ecology Committee. MAG opposed.

H.B. 1562 Multiphasic Health Testing Centers–Ambulatory-Surgi Centers

As passed, this bill would require all ambulatory surgical centers which are not a part of a hospital structure, to be licensed and regulated by DHR. H.B. 1562 also requires all multiphasic health testing centers, those facilities which do health screening and laboratory examinations without physician control, to be licensed and regulated by DHR. MAG supported.

H.B. 1625 Medical Examiners Fees

This bill would amend the current law to increase the fee the medical examiner shall receive from $35 to $50 in cases where dissection of the body is not required. In cases where dissection of the body is required, he shall receive a fee of $150; for a partial post mortem examination and autopsy, a fee of $200. H.B. 1625 was defeated in the Senate Human Resources Committee. MAG supported.

H.B. 1636 Physician's Assistants

The original H.B. 1636 extended the grandfather clause for certified P.A.'s from January 1, 1975 to July 1, 1976. A Senate substitute was added to the bill that there shall be no restriction on the number of P.A.'s a hospital could employ. This was to be established by rules and regulations of the Board of Medical Examiners.

H.B. 1788 Chiropractic Insurance

This bill would require all insurance companies to reimburse chiropractors under their health and accident insurance policies. A substitute bill, which passed the committee, was not opposed by MAG. The substitute died for lack of action in House Rules Committee.

H.B. 1797 State Health Planning and Development Agency

As passed, this bill creates the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC) mandated by the Federal Act 93-641. The creation of these two agencies under H.B. 1797 make these agencies a separate entity of state government and not under DHR. These agencies have the authority to implement the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), the federal rules and regulations promulgated under that Act, and other pertinent federal authority consistent with the laws in the State of Georgia and to insure federal funds will be provided to the State of Georgia consistent with the laws of Georgia.

H.B. 1797 specifically excludes these agencies from implementing any portion of the Certificate of Need requirements mandated under PL 93-641. MAG did not oppose.

S.B. 20 Optometric Use of Drugs

This bill, introduced in 1977 in the Senate Human Resources Committee, was studied by this committee during the Summer of 1977. The committee visited the Medical School of Emory and the Optometric School of Memphis. Thanks to the numerous MAG members who contacted members of this committee, S.B. 20 was once again assigned to an interim study committee for 1978. This, in essence, defeated S.B. 20 for this year. However, we know this will be back again in early 1979. MAG opposed.

S.B. 253 & 613 Psychology Insurance

These bills would mandate that all health and accident insurance policies have psychologists be reimbursed for what they are licensed to perform by the State. Although psychologists are a recognized professional group in Georgia, these bills are just another form of legislation mandating specific insurance coverage. MAG does not oppose psychologists but has in the past opposed mandatory insurance coverage under health and accident insurance policies. Both S.B. 253 and S.B. 613 were referred to an interim study committee. MAG opposed.

S.B. 313 Psychiatric Insurance

This bill, sponsored at the request of the Georgia Psychiatric Association, would state under the word "physician" in health policies, psychiatrists, who are medical doctors, would not be discriminated against. S.B. 313 was referred to interim study committee by The Senate Banking, Finance and Insurance Committee. MAG was in favor of the concept of this type legislation.

S.B. 369 Hypnotism

This bill would limit the use of hypnosis to medical doctors, dentists, and licensed applied psychologists. S.B. 369 passed the Senate and was put into a study committee by the House Health and Ecology Committee. MAG supported.

S.B. 383 State Medical Education Board

As passed, S.B. 383 removes from the Georgia Constitution that section dealing with State Medical Education Board. By putting this Board under statute law, said law can be amended on a year to year basis rather than by the cumbersome mechanism one has to go through to amend the Georgia Constitution. MAG supported.

S.B. 422 Public Hospitals–Staff Privileges

As passed, this bill amends current law to state that for all persons applying for hospital privileges at a public hospital, said application shall be acted upon in 90 days. This changes the current law from 60 to 90 days. MAG supported.

S.B. 426 Medical Malpractice–Minors

This bill, introduced at the request of MAG and the Georgia Chapter of the American Academy of Pediatrics, would create a statute of limitations for all persons under the age of 18. This statute would be for all those under the age of six years. An action for medical malpractice shall be brought at the date on which the negligent or wrongful act or omission occurred, within a period specified, two years before said minor's eighth birthday, whichever is later. S.B. 426 was referred to a study committee by the Senate Human Resources Committee. MAG supported.

S.B. 449, 450, 451 & 478

All of these bills pertain to the treatment of the mentally ill, alcoholics, and drug addicts. All bills were MAG supported and all bills passed.

S.B. 482 Health Care Costs

This bill states the county in which an indigent patient resides shall reimburse the county in which the indigent patient received medical treatment. S.B. 482 passed the Senate, passed the House Health and Ecology Committee, but failed to be put on the general calendar for the House Rules Committee. MAG supported.

S.B. 486 Preventative Disease: PKU Testing

As passed, this bill requires the Department of Human

Resources to promulgate rules and regulations creating a system for the prevention of mental retardation caused by phenylketonuria, galactosemia, tyrosinemia, homocystinuria, maple syrup urine disease, hypothyroidism, and other such inherited metabolic disorders as may be determined in the future to cause mental retardation if undiagnosed and untreated. MAG supported.

S.B. 570 Advertising–Dr./Doctor

As passed, this bill requires any person using Dr. or Doctor after his name to specify the type doctor he is. This only applies on letters, cards, advertisements, solicitations, etc. MAG supported.

S.B. 590 Medical Review Committee/Immunity

Introduced by MAG at the request of the Georgia Medical Care Foundation, this bill would provide immunity to any person furnishing professional counsel to or acting on behalf of and under the direction of a medical review committee, in the absence of malice or fraud. No civil or criminal action on the part of, or no cause of action for damages shall arise against any person furnishing said information. S.B. 590 passed the Human Resources Committee, was opposed by numerous attorneys in the Senate and was recommitted for study by the Senate Human Resources Committee. MAG supported.

S.B. 616 Child Abuse

As passed, this bill relates to reports of child abuse by physicians, treating personnel, institutions and others so as to provide that reports shall be made to appropriate policy authorities in the absence of a child welfare agency providing protective services. Said person making said reports are immune from liability. MAG supported.

REFERENCE COMMITTEE RECOMMENDATION:

The Committee reviewed this report and proposes the following amendment to the section dealing with H.B. 1636, Physician's Assistants: Add a new sentence at the conclusion of the paragraph which will read as follows, "MAG felt this bill was not in the best interest of the citizens of Georgia and, upon our request, Governor George D. Busbee vetoed House Bill 1636. For this courageous act all MAG members are requested to communicate in writing to the Honorable George D. Busbee, Governor, State of Georgia, State Capitol Building, Atlanta, Georgia 30334, commending him for vetoing H.B. 1636."

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests the adoption of the Legislative Committee Report as amended.

HOUSE OF DELEGATES ACTION—Delegate James Kaufmann moved to amend the Reference Committee recommendation by changing the last period to a comma, and adding the following phraseology, "and that the Speaker inform the governor of the action of this House." This amendment was adopted.

The House then adopted the report of the Committee on Legislation as amended by the Reference Committee and subsequently amended on the floor.

REFERENCE COMMITTEE C

COMMITTEE ON MEDICINE AND HUMAN VALUES

Ronald M. Hudson, M.D., Chairman
Reference Committee C

After about four years of inactivity, the MAG Committee on Medicine and Religion was resurrected, with reconstituted membership. In March, 1978, the committee requested and received a change of name to the Committee on Medicine and Human Values, a name which more accurately describes its role and charge. The Committee's activities this year included two committee meetings and written testimony provided to the Georgia legislature on the Living Will or Right-to-Die bill.

The Living Will bill has provided a concrete focus for committee work, since it raises issues of concern to our profession which are not properly in the domain of any other MAG committee. This piece of legislation was originally introduced in the 1977 Georgia legislature as House Bill 51 and was assigned to the House Committee on Health and Ecology for further study. The bill would authorize the discontinuance of life-sustaining procedures for patients with a terminal condition upon written directive (the so-called "living will") from the patient. Our committee carefully studied the bill and concluded that it was inadequate in a number of important respects and therefore should not be passed. On the other hand, we concluded that some such legislation is urgently needed to deal with the situations addressed by the bill. We communicated our conclusions to the House Committee on Health and Ecology in early January, 1978. The Living Will bill was reintroduced in the 1978 Georgia legislature as H.B. 1258 by Rep. J. Roy Rowland, a physician and member of the MAG. Our committee was happy to see that practically all of its criticisms of the earlier bill were adequately addressed in the Rowland version, and it therefore let it be known that it supported this bill, which passed the full Georgia House but was killed in the Senate Committee on Human Resources. The MAG took no official stand on the bill and did not lobby on its behalf.

The question remains whether the MAG should endorse the concept of the Living Will and lobby for the passage of appropriate legislation in upcoming sessions of the legislature. On one side of the question, it may be more appropriate that each MAG member make up his own mind about legislation affecting the patient's right to die, since the issues impinge upon one's conscience and personally-held values. On the other side, it could be argued that such legislation is urgently needed to insure the patient's right to die with dignity, and the MAG's support of such legislation may well be vital to its passage. The committee favors the latter argument and therefore puts the question before the House of Delegates in the form of a recommendation.

Our committee also discussed the concept of the hospice as a humane alternative to the care of the terminally ill. Other suggested areas of discussion are family life, MAG's position on various ethical issues, and support for physicians in relating to patients and their communities on the human level.

The committee may be able to help sponsor speakers on issues related to medicine and human values. Although we are not convinced that an MAG-sponsored program in this area would be well attended by the membership, we stand ready to assist county medical societies and other organizations in planning and identifying resources for such programs.

RECOMMENDATION

That the MAG support the concept of the Living Will as embodying and protecting the patient's right to death with dignity, and that the MAG work toward passage of the appropriate legislation in the Georgia legislature.

REFERENCE COMMITTEE RECOMMENDATION:

This report deals solely with MAG supporting legislation concerning the concept of a "Living Will" or "Right to Die" legislation.

This comprehensive subject matter has never been brought before this House before and your Reference Committee felt it appropriate that we take a stand on this issue. We further felt that any such stand should be taken by the House of Delegates and not by any smaller governing body of MAG.

RECOMMENDATION

Mr. Speaker, we suggest adoption of the Recommendation of the Committee Report on Medicine and Human Values.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Committee on Medicine and Human Values.

COMMITTEE ON MATERNAL AND INFANT HEALTH

Luella Klein, M.D., Chairman

During 1977 the Committee on Maternal and Infant Health met several times to review maternal death cases and abortions in Georgia and to discuss maternal and infant health care and legislation. The Family Health Unit provided the following report about Georgia.

Livebirths and Birth Rate

There were 78,350 livebirths in Georgia in 1976. Preliminary data indicates that there will be an increase in 1977.

There were 584 livebirths at home attended by lay midwives and there were 1,538 deliveries in hospitals by Certified Nurse Midwives.

Births to Unwed Mothers

There were 11,074 livebirths to unwed mothers during 1976. The rate fell to 139.7 per thousand in 1976.

Adolescent Pregnancies

Livebirths to adolescents represented 23.6% of births in 1976. There were 8,358 livebirths to mothers under age 18 out of a total of 18,678 adolescent livebirths. Of livebirths to unwed mothers, 55.3% were to adolescents or about 33% of all teenaged livebirths were reported born out of wedlock.

Maternal Mortality

Sixteen women died as a direct or indirect result of pregnancy during 1976, eleven black and five white. Ectopic pregnancy was the cause of death for two women. Toxemia of pregnancy was responsible or contributory in the deaths of three women, and rupture of the uterus of another. Pulmonary embolism contributed to four deaths, two of which were amniotic fluid emboli. There was one death due to postpartum sepsis and one to a cerebral hemorrhage in labor. Three were reported to be due to unspecified complications of pregnancy and one to postpartum complications.

Infant Mortality

Infant deaths have continued to decline. There were 1,259 infant deaths during 1976, a rate of 12.1/1000 livebirths for white and 22.6/1000 livebirths for black. White neonatal deaths have declined to a rate of 8.6 and postneonatal deaths to 3.6. For black infants the decline is 15.1 for neonatal deaths and 7.4 for postneonatal deaths.

Abortion

During calendar year 1976 there were 25,586 legal abortions reported to the Department of Human Resources, 22,506 were residents of Georgia and 3,080 were out-of-state residents. This is an abortion ratio of 323 abortions per thousand livebirths. There were no deaths directly attributable to legal abortion.

Thirty-one and a half percent of women aborted were under 20 years of age. Sixty-three and seven tenths percent were white and 24.2% black. Seventy percent of the patients stated that they were unmarried. Sixty-six percent reported that they were not practicing contraception prior to getting pregnant, and 19% reported at least one previous abortion. Ninety-five percent of legal abortions were obtained under 13 weeks of gestation, 4% between 13 and 20 weeks, and less than 1% greater than 20 weeks. Four fifths of the abortions were reported as "outpatient" procedures, and 95% were performed by suction curettage.

Public Health Maternal Services

During fiscal 1977, 12,405 women received prenatal care services through county health departments. The Program of Care for Medically Indigent High Risk Pregnant Women and Their Infants served 3,198 women and their infants during the fiscal year. This was an increase of 55% from the year before.

Family Planning

As of June 30, 1977, there were 109,516 women actively participating in the Department of Human Resources' statewide Family Planning Program. During fiscal year 1977 there was an unduplicated total of 148,964 patients served at 307,502 visits. Nearly one third of patients were under 20 years of age. Oral contraceptives were chosen by 62% of the patients, intrauterine devices by 11% and other methods by 25%. There were 124 sterilization procedures paid for by program funds.

Cervical Cancer Screening Program

During fiscal year 1977, the statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided 119,559 Pap smears to indigent and medically indigent patients receiving health services from local health clinics. Since the beginning of the program in 1967, 704,160 Pap smears have been done, and a diagnosis of malignancy has been made in 1,136 cases. Ninety percent of all malignancies have been preinvasive.

RECOMMENDATION

The Maternal and Infant Health Committee states that

abortions, as other health care, should be financed for those unable to pay. If federal funds do not pay for abortions for low income Georgia women through Medicaid, the Maternal and Infant Health Committee recommends that MAG recommend that funds from the State of Georgia should be made available for abortion for Georgia women who are unable to pay.

REFERENCE COMMITTEE RECOMMENDATION:

The discussion centered around the recommendation that state funds be made available for abortions for low income Georgia women through Medicaid. Since there are no matching federal funds this would be a total state expenditure.

Though the discussion in no way dealt with the economic considerations of this recommendation, we would like to point out that terminating these pregnancies early rather than letting them go to full term delivery would save the state approximately one-half million dollars. At no time during the discussion did anyone deem to place a monetary value on human life; however should the state enact this policy it would not cost the taxpayers further expenditures, and we felt this should be noted.

RECOMMENDATION

Mr. Speaker, we suggest adoption of the Recommendation of the Committee Report on Maternal and Infant Health.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Committee on Maternal and Infant Health.

COMMITTEE ON THIRD PARTY RELATIONS

Charles D. Hollis Jr., M.D., Chairman

The Committee on Third Party Relations had a frustrating year in attempting to accomplish its primary mission, that of obtaining under Medicare a single area prevailing fee for reimbursement purposes. Discussed below is the present status of this effort. In addition, other information which should be of interest ot the membership is noted.

Medicare: Converting Georgia to a Single Area Prevailing Fee

Douglass M. Richard, Southeastern Director of Medicare, has worked with the MAG staff and with the central office of Medicare in Baltimore in an effort to accomplish the change to a single area prevailing fee for Georgia, as directed by the 1977 MAG House of Delegates. Medicare policy one year ago was that upon request of a state medical society, the fee patterns could be reviewed and if a "non inflationary" statewide prevailing fee could be identified, that this would be adopted for reimbursement purposes. However, during the year when Mr. Richard and his associates were attempting to determine the proper method of reviewing the data in the State, HEW developed a new policy involving a much more complicated analysis of fee patterns and apparently making it very much more difficult for states to arrive at a single area prevailing fee. This new methodology, SAW II (service area wide) would analyze separately the fee data for every specialty in every county and identify patterns on a county

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by county and specialty by specialty basis. Any relatively small deviation in charging patterns, roughly about ten per cent, would require the establishing of a new area for payment purposes. In a cursory look at patterns in Georgia, instead of establishing a single area prevailing fee, this could result in as many as seven areas. The explanation from HEW is that under the present law the "usual, reasonable and customary" principle must be used and the new method of analyzing fee patterns is a more precise way of establishing the usual, reasonable and customary fee.

HEW is still willing to make a statewide study under the new SAW II method, but once undertaken the findings of the study are binding, giving the physician in the state no option as to whether or not to accept the new payment allowances. Mr. Richard advised the Committee that there was good likelihood that the present effort by MAG to assure more equitable payments for physicians in rural areas would *not* be accomplished by pursuing further fee analyses and that the likelihood is that situation for small town and rural physicians would be worsened by modifications likely to result.

It was noted that the HEW directive that findings obtained under the new SAW II studies to establish payment areas be binding, once undertaken, was a bureau directive and did not at this point have the effect of Federal law. Therefore, it was felt by the Committee that an effort should be made to obtain information regarding fee patterns in Georgia which would allow representatives of the Medical Association of Georgia to determine whether or not an HEW "SAW II" analysis would be in the best interests of the physicians and the patients in Georgia. It was also suggested that the amount of work involved in establishing the new methodology, SAW II, had been so extensive and so expensive that this new type of study might be done on a national basis within the next year or two, even without the request of the Medical Associations. Thus the HEW might already be planning a revision of payment areas throughout the county.

The Committee decided that a request be made to the Georgia congressional delegation by the Committee to get HEW to perform a *non-binding* study of the effects of an attempt to implement a single usual and customary fee system for Medicare patients in Georgia, as provided for in the SAW II methodology. This request will be forwarded to the Congressmen and Senators. The Committee also recommended that the MAG House of Delegates direct the MAG Board of Directors to appropriate sufficient funds to perform a fee study on a basis sufficient to indicate the likely effect of implementing a single statewide prevailing fee mechanism upon the doctors in Georgia,

(a) if the Department of HEW reaffirms its unwillingness to perform such a study on a non-binding basis, or

(b) if the Department of HEW fails to perform such a study at all.

HCFA

The Health Care Financing Agency is new and will be the responsible agency for administering both Medicare

and Medicaid. Medicare has been taken from the direction of the Social Security Administration. One of the first stated aims of HCFA is to establish a uniform coding system, but there is question whether this will prove to be the CPT-IV system, since there is indication that a five digit code might be somewhat inflationary.

Medicaid now uses the five-digit code but Medicare still uses a four-digit code as developed by Prudential. Representatives from Prudential say that they have the capability to translate the five-digit code to the four-digit but the coding under the four-digit method of Prudential by physicians would expedite their claim processing and would speed up payment of claims. At the last annual session the MAG established the policy to encourage all its members to code procedures under the CPT method, since all carriers now have the capability to translate this code. General use of it by all physicians would encourage carriers to adopt this ultimately as the one uniform code.

Prudential as Agent for Medicare

Mr. Ted Snyder reported that 86 per cent of Medicare claims are processed within ten to fifteen days. Prudential has been in the process of working out with Atlanta Blue Cross-Blue Shield an arrangement to coordinate Medicare and supplemental coverage with a magnetic tape "tie in." When this is done it will also be available to Columbus Blue Cross-Blue Shield. Mr. Snyder also reiterated the policy that after the death of a patient unless assignment is accepted, the doctor must have from the family a receipt that the account has been paid in full before Medicare can make its reimbursement. If assignment has been accepted, Medicare will pay the usual 80 per cent of the UCR allowance for that physician.

Medicaid

Mr. David Poythress, Commissioner, Bureau of Medical Assistance (Medicaid) gave a rather encouraging report about the progress of administering Medicaid in Georgia. Eighty per cent of claims submitted are now being processed in twenty to twenty-five days. On claims too old to qualify for federal support funds, Mr. Poythress has obtained this year $1.8 million to pay with 100% state funds claims dating back to 1974. With the improvement in processing time, the requirement that claims be submitted within ninety days will very likely be enforced in the future.

For hospitals, pharmacists, and a few large physician groups, Medicaid is making it possible to provide claims input through the use of a magnetic tape. This would minimize the administrative work required by providers in submitting claims, would be less subject to error, and would expedite payment of the claims. Since there is significant expense involved in setting up the mechanism, it would not be practical for individual physicians. However, Mr. Poythress says this could be done in a cooperative effort by physicians grouping themselves, or by coordinating the transmission of claims information through a county medical society "tie-in."

Mr. Poythress also stated that a new physician enrollment form is being developed, with information limited to that contained on a single page. Once established this enrollment would not require renewal every year and would continue until voluntarily terminated by the physician.

Blue Cross-Blue Shield

Both the Columbus and Atlanta Blue Shield plans are experiencing considerable trouble and expense handling claim information submitted on a "Super Bill." Even though there is obviously some advantage to a doctor in utilizing this way of submitting information, it increases cost of processing forms and thus increases the cost of insurance for the patient. Representatives from the Blues stated that they have undergone considerable expense to adapt their system to the uniform AMA claim form and requested that the Committee urge the membership to use the uniform claim rather than the "Super Bill."

The Committee voted to inform its members of the problems experienced by the Blues in handling the "Super Bill" and encourage the membership to use the AMA uniform claim form to submit information to all carriers except for Medicaid. Because of certain government requirements, Medicaid is still not able to accept the AMA uniform claim form.

General Motors Vision Program

It was reported to the Committee that the United Auto Workers have contracts to provide eye care for workers with provisions that only if a physician signs a provider agreement will he be paid the full amount allowed under the contract. A physician who does not participate in the plan is paid less than the full amount. A list of participating physicians is given to the patients covered under the contracts.

The Committee felt that it was not desirable to coerce physicians to sign provider agreements with insurance companies and voted to ask MAG to present the problem to the insurance carriers and request that they not sell contracts with this requirement. It was also felt that this problem might well become a more generalized one and that the MAG should explore other ways to discourage the offering of contracts with provider agreements.

The Medicare Medicaid Reform Bills

Apparently there has been little agreement as to how to proceed with the present bill and it is felt that no action will be taken on it this year.

Catastrophic Health Insurance

Again this year a bill was introduced to the State Legislature to require insurance carriers to make such coverage available to all who buy Health Insurance. Not much progress has been made and apparently this will not be acted on at this session.

The Committee voted to reaffirm the position of the last House of Delegates endorsing the concept of voluntary catastrophic health insurance and encouraging MAG to continue to look for means of supporting the small number of individuals who suffer financial ruin because of catastrophic illness.

RECOMMENDATIONS

1. The MAG should appropriate sufficient funds to allow the MAG Board of Directors to perform a study of prevailing fees in the State, sufficient to indicate the likely effect of implementing a single area prevailing fee mechanism in Georgia, if HEW refuses to make such a study without binding Georgia to the findings.

2. Indicate again to the membership through the *Newsletter* the desirability of utilizing the uniform AMA claim form for reporting to all third parties except Medicaid.

3. Establish a policy that MAG oppose the use of insurance contracts which encourages the signing of a

provider agreement by awarding higher fees to participating physicians.

4. Continue to explore ways to increase voluntary participation in catastrophic health insurance programs and to minimize the number of people who suffer financial ruin from the cost of severe or prolonged illness.

SUPPLEMENTAL REPORT COMMITTEE ON THIRD PARTY RELATIONS

Charles D. Hollis Jr., M.D., Chairman

As noted in the report, the Committee voted to ask the Georgia representatives in Washington to request HEW to reconsider its decision to make any findings regarding fee patterns under a "SAW II" study binding on a state.

While in Washington for the MAG Congressional luncheon, the chairman mentioned this to Senator Talmadge and was referred to Mr. Jay Constantine, senior member of the staff of the Subcommittee on Health of the Senate Finance Committee. After considerable discussion with Mr. Constantine and his assistant for Medicare-Medicaid affairs, Mr. Robert G. Hoyer, Mr. Tom Tierney, Chief of the Medicare division of HEW, was contacted. Mr. Tierney said that he was not aware that his subordinates in the HEW office had directed that findings under a "SAW II" study, once undertaken, would be binding. He agreed to investigate further and then report back to us in Georgia.

The next day Mr. Hoyer notified us that Mr. Tierney had directed that the first "SAW II" study should be performed in Georgia, and that the statistical findings would not be conclusive. Other factors than the statistical methodology would be considered in arriving at area designations for reimbursement purposes, and no changes would be made without consultation with representatives of the Medical Association of Georgia.

Mr. Douglass M. Richard, reporting for Mr. Tierney, contacted us and confirmed Mr. Hoyer's information. He stated that there would be no "strings" attached to the study, and that there would be no requirement to make any change that MAG does not consider desirable for the physicians and the patients of the State. Prudential has been notified to proceed on a high priority basis. However, since July 1, 1978 is time for re-adjustment of fees, this will have to be completed before the study can begin.

It seems that the MAG has obtained very favorable consideration of its requests to modify the reimbursement inequities, both from the Senate Subcommittee on Health and from the central HEW office.

REFERENCE COMMITTEE RECOMMENDATION:

In reviewing this comprehensive report we again commend Dr. Charles Hollis for his tireless efforts as chairman of this Committee. Because of the multi-faceted subject matter contained in this report we suggest the following:

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests the Third Party Relations Committee Report 45 and the Supplemental Report 45A be filed.

Recommendation 1 of this report is a request for funds for MAG to perform a study of prevailing fees in the state. The author of the committee report presented additional information in his supplemental report indicating that this can perhaps be done through his committee in cooperation with appropriate federal agencies. The author thought that Recommendation 1 was no longer appropriate, however we feel that should he not get such accomplished, MAG should still consider spending funds for this purpose and therefore suggests the following substitute recommendation:

"That the Committee on Third Party Relations continue to seek a study of prevailing fees in the state, sufficient to indicate the likely effect of implementing a single area prevailing fee mechanism in Georgia, but that if they are unsuccessful in doing so, that the Committee should request that the MAG Board of Directors consider expending funds for such study."

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RECOMMENDATION

Mr. Speaker, we suggest the original Recommendation 1 be not adopted and propose adoption of Substitute Recommendation 1.

Recommendation 2 encourages use of the uniform AMA claim form. Your Reference Committee heard no testimony supporting this but heard considerable testimony supporting the "super bill" type billing attached to appropriate insurance forms, a method of decreasing office expenses as discussed at our last MAGNET Conference.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests Recommendation 2 be not adopted.

Recommendation 3, establish a policy that MAG oppose the use of insurance contracts which encourages the signing of a provider agreement by awarding higher fees to participating physicians.

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests adoption of Recommendation 3.

Recommendations4: The Reference Committee agrees with Recommendation 4 but believes two new sentences should be added to read as follows: "Due to the extremely low incidence of illnesses which create catastrophic financial problems, catastrophic health insurance is relatively inexpensive, and much less so than a mandated federally-run program. We encourage our Communications Committee to disseminate this information to the public."

RECOMMENDATION

Mr. Speaker, your Reference Committee suggests adoption of Recommendation 4 as amended.

HOUSE OF DELEGATES ACTION—Voted to not adopt Recommendation 1 as proposed by the Third Party Relations Committee and adopted in lieu thereof the substitute recommendation proposed by the Reference Committee.

Voted to not adopt Recommendation 2.

Delegate Joe Bailey proposed a substitute recommendation which reads as follows: "Establish a policy

that MAG is unalterably opposed to any insurance contract which encourages the signing of a provider agreement by awarding higher fees to participating physicians. When insurance contracts of this type are discovered, MAG should immediately and vehemently oppose any such contracts. MAG should immediately determine the constitutionality and legality of such provider agreements from the legal counsel and report back to the Board of Directors at its June meeting. Delegate John Heard moved an amendment by addition to the Bailey substitute which was agreed to by Dr. Bailey. That addition provided: "and further, that MAG refrain from the use of the term provider agreement, as well as health care, health care industry, health care delivery, health care professionals, providers, and consumers, when referring to physicians, the practice of medicine, medical care, and patients. Also, MAG should encourage third party payors to limit use of the term medical staff to apply only to physicians." This substitute for Recommendation 3 was then adopted.

Delegate Edmund Molnar moved to amend Reference Committee Recommendation 4 by inclusion of the word voluntary so that Recommendation 4 would then read, "Due to the extremely low incidence of illnesses which create catastrophic financial problems, voluntary catastrophic health insurance as relatively inexpensive, and much less so than a mandated federally run program. We encourage our Communications Committee to disseminate this information to the public." The House then voted to adopt Recommendation 4 of the Committee on Third Party Relations as amended by addition by the Reference Committee, and as further amended on the floor.

RESOLUTION 3
AMA MEMBERSHIP OPINION POLL REGARDING NATIONAL HEALTH INSURANCE

DeKalb Medical Society

WHEREAS, in June, 1976, the AMA House of Delegates mandated a national survey of physicians on critical issues facing the medical profession, and

WHEREAS, the resulting survey *did not* ask the membership whether they favored national health insurance or whether they feel the AMA should sponsor a national health insurance plan, and

WHEREAS, neither the economy nor the presently available health manpower can withstand the advent of national health insurance, resulting in the rationing of health care and leading to unnecessary suffering and financial burden for our patients, and

WHEREAS, the implementation of national health insurance is the most important issue facing organized medicine today, and

WHEREAS, national and local polls continue to show that people are satisfied with the health care system and are basically opposed to a tax-supported national health care program, and

WHEREAS, the MAG House of Delegates is on record in opposition to national health insurance in any form and also opposes the AMA sponsorship of a national health insurance plan, THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia introduce another resolution at the June 1978 Annual Meeting of the American Medical Association directing the AMA to immediately conduct a membership opinion survey that asks the following two questions:

1. Are you in favor of the enactment of a National Health Insurance Program in this country?

2. Do you believe the American Medical Association should sponsor a National Health Insurance proposal?

and BE IT FURTHER

RESOLVED, that this resolution also direct that if the results of this survey reveal that the physicians of this country oppose national health insurance or the AMA's sponsorship of a national health insurance plan, the American Medical Association immediately withdraw its national health insurance legislation (HR 1818—The Comprehensive Health Care Insurance Act of 1977).



Richard Vincent, general counsel to the Association, answers legal questions relating to matters before the House.

RESOLUTION 5
BALANCING THE FEDERAL BUDGET

Louis H. Felder, M.D.

WHEREAS, fiscal responsibility is essential to the survival of any country, and

WHEREAS, government programs that preclude the possibility of fiscal responsibility are catapulting this country into oblivion, and

WHEREAS, thoughtful, productive people across the country are viewing this with alarm, and

WHEREAS, those people who are contributing their efforts to the American way of life need reassurance that their efforts will not be in vain, and

WHEREAS, President Carter has promised the American people a balanced budget; NOW THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia House of Delegates initiate, endorse, encourage, promote, and promulgate through their own state legislature, through the medical associations and all other concerned parties of the other 49 states, and the American Medical Association and other nationwide entities, a program to have all state legislatures pass a resolution to mandate the federal government to hold a constitutional convention in congress to outlaw deficit spending; to make it unlawful for the federal government to spend or commit itself to spend more in any given fiscal year than its income for that year.

RESOLUTION 18
UNITED STATES CONGRESS H.R. 1818

Crawford W. Long Medical Society

WHEREAS, the Medical Association of Georgia has voted its opposition to socialized national health insurance schemes in any form, and

WHEREAS, the American Medical Association supported H.R. 1818 is indeed a plan of government sponsored and controlled medicine, and

WHEREAS, funding for the American Medical Association supported H.R. 1818 is through mandatory payments relying heavily upon mandatory employer taxation and allowing payments for services only through an agency of government created by this bill, and

WHEREAS, this American Medical Association supported H.R. 1818 disallows and otherwise prohibits billing of patients directly by physicians

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia is in complete opposition to the concept and language of H.R. 1818, and furthermore demands that the American Medical Association withdraw from consideration before the United States Congress H.R. 1818 and its companion Senate Resolution.

RESOLUTION 22
NATIONAL HEALTH INSURANCE

Medical Association of Atlanta

WHEREAS, the present U.S. Government Administration has announced its intention of instituting a national health insurance system, and

WHEREAS, the federal government has insisted that this program be mandatory (i.e. compulsory) for all citizens, and

WHEREAS, 92% of all Americans are presently covered to some extent by private or public health insurance programs and do not require such a massive federal health insurance scheme, and

WHEREAS, the vast majority of Americans have expressed satisfaction in our private medical care system and strong preference for a private rather than a public health delivery system, and

WHEREAS, the Administration has indicated that financial support for a national health insurance system shall come from taxes imposed on employees and employers, and

WHEREAS, added taxes patterned after the present Social Security method of taxation would result in excessive taxation and an intolerable burden to the American worker, and

WHEREAS, a national health insurance system would produce the false illusion of "free" health care and would drastically increase the demands for medical services and cause the total costs of medical care to increase greatly and therefore contribute to a significant rise in the rate of inflation, and

WHEREAS, federal funding of medical care is almost certain to lead to federal control of the practice of medicine and a general decrease in the quality of health care provided, and

WHEREAS, federal control of medical practice will likely result in federal inspection of medical records and will destroy the confidential relationship of the physician and his patient,

REFERENCE COMMITTEE C

NOW, THEREFORE, BE IT RESOLVED, that the Medical Association of Georgia reaffirm its determination to oppose adamantly by any and all legal means possible any scheme to create a comprehensive, "universal and mandatory" national health insurance program financed through "employer and employee shared payroll taxes, and general tax revenues." (Quote from address by President James E. Carter on National Health Policy, Washington, D.C., on April 16, 1976.)

REFERENCE COMMITTEE RECOMMENDATION:

Your Reference Committee considered these four resolutions simultaneously. All of these resolutions dealt in one form or another with national health insurance and we felt it appropriate to consider them together. Some of these topics have been discussed in this House before and only need restatement. For these reasons we felt it would be better to substitute a statement of policy for the above four resolutions.

"The Medical Association of Georgia reaffirms its opposition to any form of national health insurance, including HR 1818 sponsored by the AMA. We reviewed the AMA questionnaire sent out in 1977 and feel that it did not accomplish what this House requested of the AMA in 1976. We feel that the Speaker of this House should write the AMA and express disappointment that they did not poll the membership of the AMA to seek their true feelings about national health insurance.

"We feel it would be a folly for national health insurance to be adopted at the present time with the rampant inflation in our nation and with the large annual federal deficits. We, therefore, direct the Medical Association of Georgia to ask the Georgia General Assembly to pass a resolution requesting Congress to balance the federal budget annually. We furthermore would like to ask the Georgia Assembly to pass a resolution requesting a Constitutional Convention be held in order to require the federal government to balance its budget.

"We feel that MAG should make its actions known to the other 49 State Legislatures, the other 49 Medical Associations and other appropriate bodies and associations. We direct our AMA delegation to seek AMA support for this action by submitting the appropriate resolution at the AMA meeting in June, 1978."

RECOMMENDATION

Mr. Speaker, we suggest Resolution 3, Resolution 5, Resolution 18 and Resolution 22 be not adopted and propose adoption of the substituted policy statement.

HOUSE OF DELEGATES ACTION—Delegate R. Robert Lanier moved to amend the substitute statement of policy as proposed by the Reference Committee by adding a new sentence following the third sentence of that substitute. The new sentence would read, "Furthermore, that the Medical Association of Georgia reaffirm its determination to oppose adamantly by any and all legal means possible any scheme to create a comprehensive 'universal and

mandatory' national health insurance program financed through employer and employee to share payroll taxes and general tax revenues.'' That amendment was adopted.

The House then voted to not adopt Resolutions 3, 5, 18 and 22 and adopted instead the proposed substitute policy statement as amended on the floor.

RESOLUTION 6
SOCIAL SECURITY TAX

Hall County Medical Society

WHEREAS, Social Security tax is prejudicial and discriminatory, and

WHEREAS, the tax is levied on segments of the population by law. Other segments, i.e., bureaucrats, politicians, and government employees have the option whether or not they shall participate, making Social Security a discriminatory tax to those who have no option. Now therefore be it

RESOLVED, that all citizens should be treated in the same manner; bureaucrats, politicians, or government employees; that all citizens shall have the option to participate or reject Social Security, and be it further

RESOLVED, that if this tax is not administered equally to all citizens, we will respectfully assume and exercise the right to withdraw or accept Social Security tax on December 31, 1979.

REFERENCE COMMITTEE RECOMMENDATION:

Your Reference Committee submits the following resolution as a substitute to Resolution 6:

WHEREAS, Social Security Tax is prejudicial and discriminatory, and

WHEREAS, the tax is levied on segments of the population by law, other segments, i.e., government employees have the option whether or not they participate, making Social Security a discriminatory tax to those who have no option. NOW THEREFORE, BE IT

RESOLVED, that all citizens should be treated in the same manner, that all citizens should have the option to participate or reject Social Security, and

BE IT FURTHER RESOLVED, that a copy of this Resolution be transmitted to Georgia's Congressional Delegation.

RECOMMENDATION

Mr. Speaker, we suggest adoption of Substitute Resolution 6.

HOUSE OF DELEGATES ACTION—Adopted substitute Resolution 6 as proposed by the Reference Committee.

Chairman Heard expressed appreciation to the MAG Committee Chairmen who appeared before his Reference Committee and to the other interested members who appeared and also thanked the members of his Committee and the Speaker for the help and guidance shown to him.



President Milton I. Johnson

NEW BUSINESS

Dr. Jack Menendez, Vice Speaker, moved that MAG donate $500.00 to the Georgia Academy of Family Practice Retirement Fund for the purpose of helping to establish a chair of family practice at the Medical College of Georgia. The matter was duly seconded and adopted.

ANNOUNCEMENT OF ELECTION RESULTS

The Tellers Committee, having completed their tabulations of the election results, the Speaker announced the following officers elected: President-Elect—Earnest C. Atkins, Second Vice President—Richard H. Griffin, Secretary—William D. Logan, Treasurer—James H. Sullivan, AMA Delegates—Harrison L. Rogers, J. Daniel Bateman, AMA Alternate Delegates—H. Hilt Hammett and William W. Moore.

ADJOURNMENT

On motion duly made and seconded, the House of Delegates adjourned the final session at 2:45 p.m. The Speaker then immediately turned the gavel over to Milton I. Johnson, M.D., president of the Association, for the purpose of presiding over the final general session.

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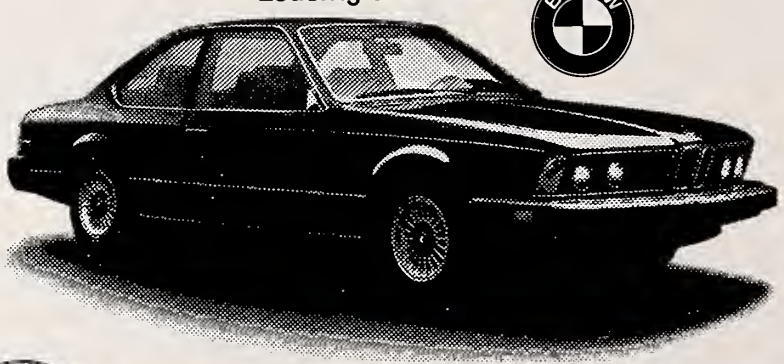
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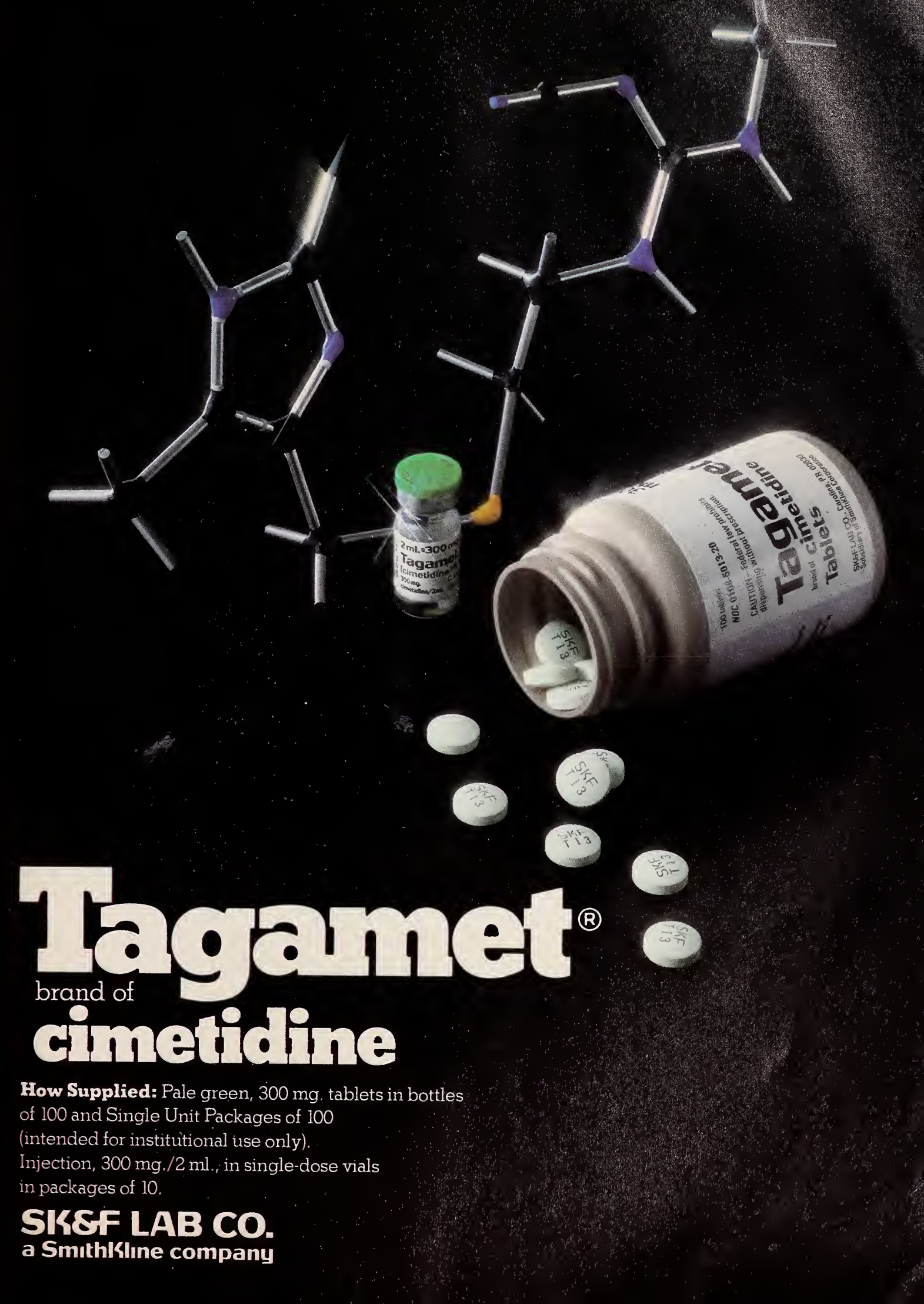
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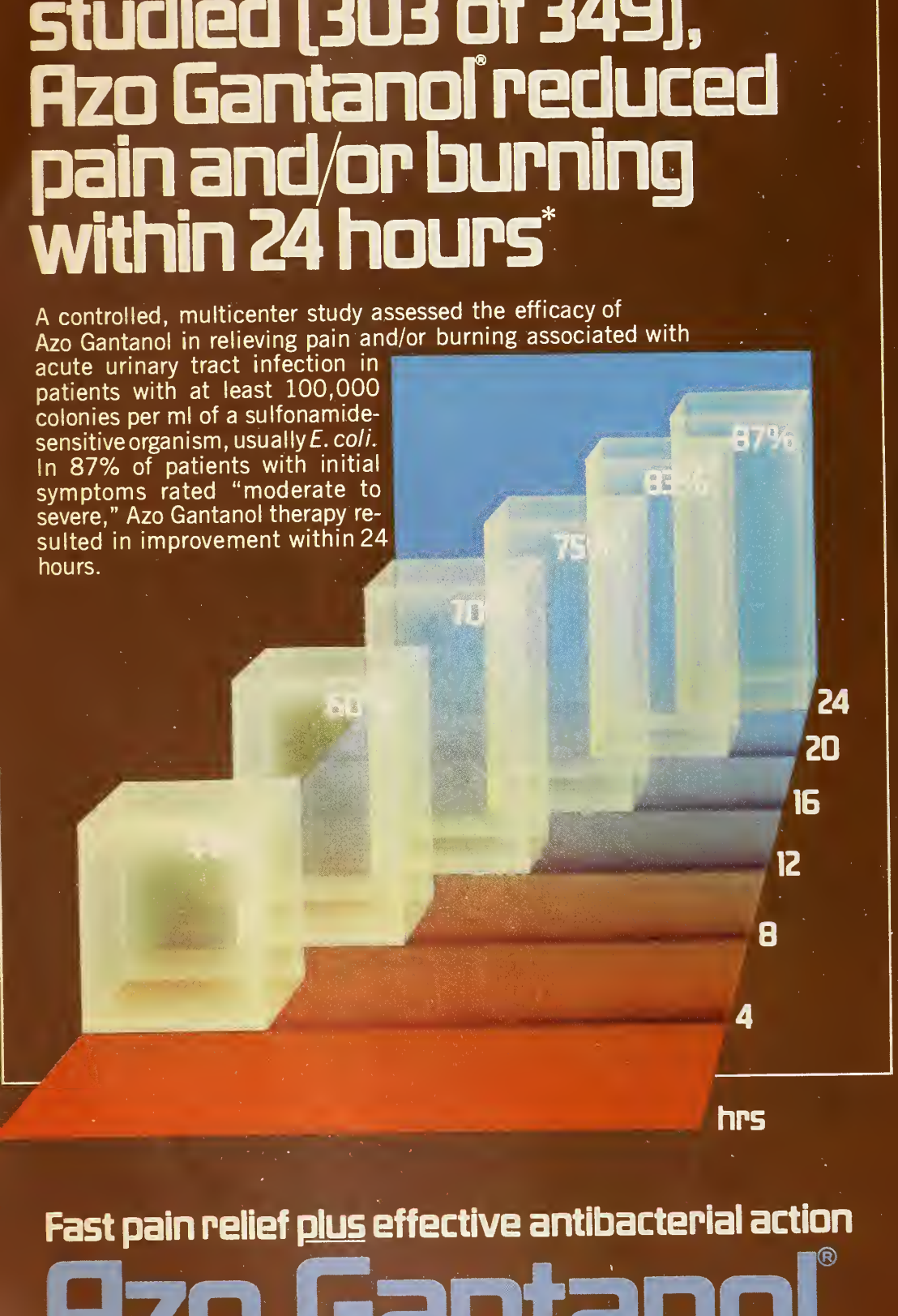
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Before prescribing, please consult complete p uct information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organ (usually *E. coli, Klebsiella-Aerobacter, Staphy coccus aureus, Proteus mirabilis,* and, less fr quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: fully coordinate *in vitro* sulfonamide sensitivit tests with bacteriologic and clinical response aminobenzoic acid to follow-up culture media increasing frequency of resistant organisms li the usefulness of antibacterials including sul fonamides.** Measure sulfonamide blood level variations may occur; 20 mg/100 ml should b maximum total level.

Contraindications: Children below age 12; su fonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is con dicated in glomerulonephritis, severe hepatit uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not estab Deaths from hypersensitivity reactions, agran tosis, aplastic anemia and other blood dyscra have been reported and early clinical signs (s throat, fever, pallor, purpura or jaundice) ma dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with paired renal or hepatic function, severe aller bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria stone formation.

Adverse Reactions: *Blood dyscrasias* (agran ulocytosis, aplastic anemia, thrombocytope leukopenia, hemolytic anemia, purpura, hyp thrombinemia and methemoglobinemia); *all reactions* (erythema multiforme, skin eruptio Stevens-Johnson syndrome, epidermal necro urticaria, serum sickness, pruritus, exfoliati dermatitis, anaphylactoid reactions, periorb edema, conjunctival and scleral injection, p sensitization, arthralgia and allergic myocar *G.I. reactions* (nausea, emesis, abdominal p hepatitis, diarrhea, anorexia, pancreatitis a stomatitis); *CNS reactions* (headache, perip neuritis, mental depression, convulsions, at hallucinations, tinnitus, vertigo and insomn *miscellaneous reactions* (drug fever, chills, nephrosis with oliguria and anuria, periarter nodosa and L. E. phenomenon). Due to cert chemical similarities with some goitrogens, uretics (acetazolamide, thiazides) and oral glycemic agents, sulfonamides have caused instances of goiter production, diuresis and glycemia. Cross-sensitivity with these agent exist.

Dosage: Azo Gantanol is intended for the a painful phase of urinary tract infections. *Us adult dosage:* 2 Gm (4 tabs) initially, then (2 tabs) B.I.D. for up to 3 days. If pain per causes other than infection should be soug After relief of pain has been obtained, cont treatment with Gantanol (sulfamethoxazole be considered.

NOTE: Patients should be told that the ora dye (phenazopyridine HCl) will color the uri

Supplied: Tablets, red, film-coated, each co ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 5

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BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

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MAG Final Session
Sunday, April 16, 1978

President Milton I. Johnson convened the Final Session of the 1978 Annual Session Business Meeting and expressed his appreciation to Drs. Buchanan and Menendez for their handling of the business of the House of Delegates.

Installation of Officers

Dr. Johnson asked the incoming president, the other officers of the Association, the AMA delegates and alternates, and directors and alternate directors to assemble in front of the speaker's platform for the purpose of taking the oath of office as follows: President—Carson B. Burgstiner, Savannah; President-Elect—Earnest C. Atkins, Decatur; Second Vice President—Richard A. Griffin III, Cartersville; Secretary—William D. Logan Jr., Atlanta; Treasurer—James H. Sullivan, Columbus;

AMA Delegate—Harrison L. Rogers Jr., Atlanta; AMA Delegate—J. Daniel Bateman, Albany; AMA Alternate Delegate—H. Hilt Hammett Jr., LaGrange; AMA Alternate Delegate—William W. Moore, Atlanta;

Ninth District Director—Rupert H. Bramblett, Cumming; Ninth District Alternate—L. Austin Flint, Canton; Tenth District Director—M. A. Hubert, Athens; Tenth District Alternate—William M. Headley, Milledgeville;

Bibb County Medical Society Director—Beverly B. Sanders Jr., Macon; Bibb County Medical Society Alternate—Rodney M. Browne, Macon; Cobb County Medical Society Director—Charles R. Underwood, Marietta; Cobb County Medical Society Alternate—Frank W. McKinnon, Marietta; DeKalb Medical Society Director—John P. Heard, Decatur; DeKalb Medical Society Alternate—Roy W. Vandiver, Decatur; Floyd-Polk-Chattooga County Medical Society Director—John I. Dickinson, Rome; Floyd-Polk-Chattooga County Medical Society Alternate—Lee H. Battle, Rome; Medical Association of Atlanta Director—T. J. Anderson Jr., Atlanta; Medical Association of Atlanta Alternate—William D. Logan Jr., Atlanta; Richmond County Medical Society Director—Ronald F. Galloway, Augusta; Richmond County Medical Society Alternate—Henry D. Scoggins, Augusta.

President Johnson administered the oath of office to the assembled new members of the MAG Board of Directors and declared these officers duly installed. Dr. Johnson then passed the gavel as the symbol of leadership to the incoming president, Dr. Carson Burgstiner, who expressed his appreciation for the honor of being elected president for the year 1978-79. Dr. Burgstiner then presented to Dr. Johnson the President's Key and a gavel plaque as a sign of appreciation.



Milton I. Johnson passes the presidency to Carson B. Burgstiner.

Dr. Burgstiner announced the date and site of the MAG annual meeting—House of Delegates for the following two years as follows:

1979—Savannah, April 20, 21, 22, DeSoto Hilton Hotel;

1980—Atlanta, April 25, 26, 27, Atlanta Hilton Hotel.

Dr. Burgstiner announced the official attendance at the 124th Annual Session as follows:

Delegates	183
Alternate Delegates	20
Members	40
Guests	18
Auxiliary	125
Total Registration	381

Adjournment

On motion duly made and seconded, Dr. Burgstiner adjourned the 124th Annual Session of the Medical Association of Georgia at 2:55 p.m.

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Election of MAG Officers

ONE OF THE HIGHLIGHTS of each Annual Session is the election and installation of officers for the Association. The following are brief sketches of your officers for the year 1978-79, designed to introduce you to these highly qualified leaders.

President

Carson B. Burgstiner, M.D., is the youngest president in the history of MAG. A graduate of the University of Miami School of Medicine, he has an Ob/Gyn practice in Savannah. He has served MAG for many years as a member of the Board of Directors of GaMPAC, member of the Board of the Georgia Medical Care Foundation, and member of the Legislative and Annual Session Committees. He has served his county society as chairman of its Quackery Committee.

President-Elect

Earnest C. Atkins, M.D., has served MAG as secretary for the past six years. A native of Marietta who received his M.D. degree from Emory University School of Medicine, he practices general surgery in Decatur. He is a past president of the Georgia Medical Care Foundation and of the DeKalb County Medical Society. He is currently president of the medical staff of Decatur Hospital and is a clinical assistant professor of surgery at Emory.

First Vice President

L. Newton Turk III, M.D., who served as first vice president in 1977-78, is a surgeon specializing in thoracic and cardiovascular surgery. A native Atlantan, he received his M.D. degree from Emory University. He has served the Medical Association of Atlanta as president, treasurer and chairman of the Board of Trustees.

Second Vice President

Richard A. Griffin III, M.D., is a general surgeon practicing in Cartersville. Born in Dahlonega, he received his M.D. degree from the Medical College of Georgia. He is a past president of the Bartow County Medical Society and is currently a board member of the Appalacian HSA.

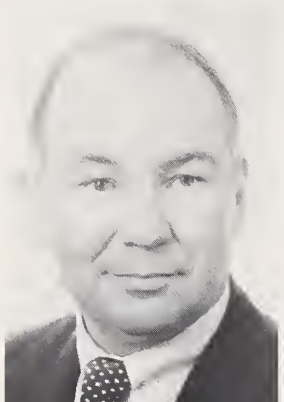
Secretary

William D. Logan Jr., M.D., is a thoracic and cardiovascular surgeon in Atlanta, where he received his M.D. degree from Emory University School of Medicine. He is a past president of the Medical Association of Atlanta and the Atlanta Lung Association and is a former secretary of the Georgia Chapter, American College of Chest Physicians.

Treasurer

James H. Sullivan, M.D., a Columbus urologist, received his M.D. degree from the Medical College of Georgia and is also a graduate pharmacist. He is a past president of the Muscogee County Medical Society and served MAG as first vice president and second vice president before becoming treasurer in 1977.

president's letter



Cost Containment: Is the Physician to Blame?

I THINK NOT. We have the best system of quality health care in the world today. We do have a maldistribution of medical manpower within our national health care system. And we do need an increased orientation toward preventive medicine. Physicians are taught from the onset to treat diseases, and are preoccupied with "illness care." We have not publicly asserted ourselves in the forefront of preventive health care.

Cost containment cannot be controlled while our patients gorge themselves on nutrient-deficient refined foods, imbibe alcohol excessively, smoke assorted varieties of harmful weeds and tobacco and drink caffeinated drinks, including coffee, tea and soft drinks. Those engaged in these activities inevitably increase their chances of becoming chronically ill. Physician and patient education in clinical nutrition should be our priority with an emphasis on presentation of the facts garnered from animal and human nutrition research and experiments.

There are certain other aspects of health care cost containment beyond physicians' control: the costs attached to defensive medicine; the result of the professional liability crisis; delays and inequities of the third-party payment system; escalating employee benefits; the new three R's of health care—rules, regulations and reports, and most importantly the impact of bureaucracy on the cost of health care.

Why cannot the government concentrate on balancing the budget and curbing inflation and allow the last bastion of freedom, the private health care industry, to solve the problems of health care cost and containment?

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

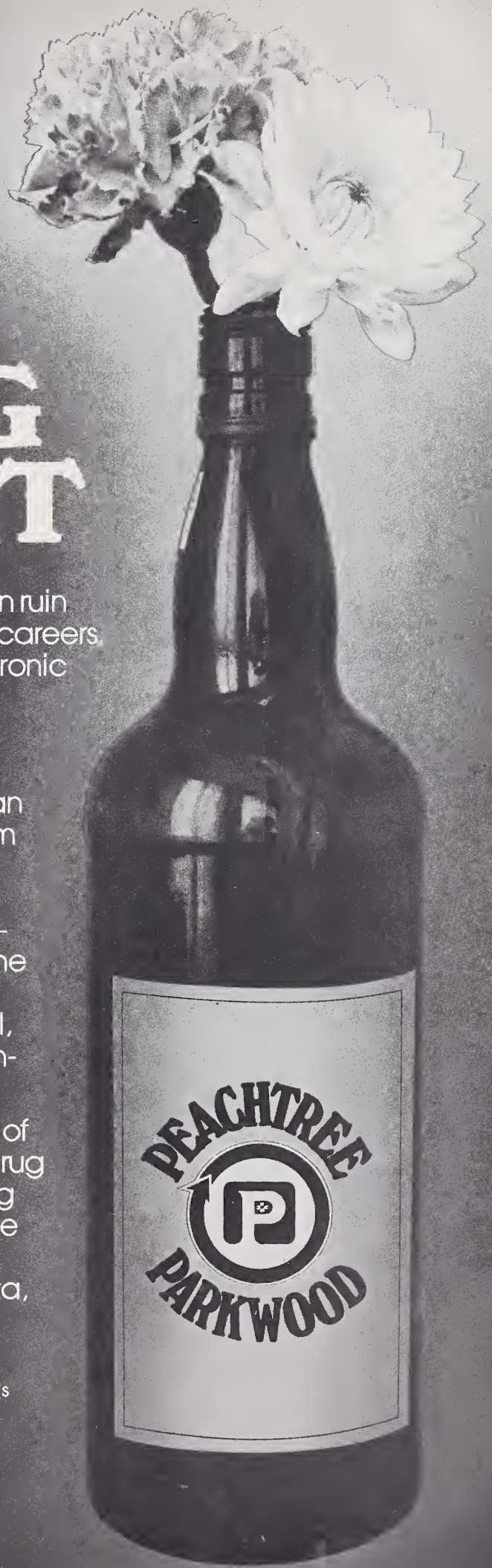
A SOBERING THOUGHT

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I've told this before . . .

(Editor's note: A mother learns not to jump to conclusions in this story shared by Dr. Kellum. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Balls Will Be Balls

THIS HAPPENED in the office of a pediatrician friend of mine. A four-year-old boy was jumping up and down on the divan in the reception room and raising hell in general, paying no attention to the correcting of his mother. Finally, she had stood all she could. She picked him up and slammed him down on the sofa as hard as she could and said, "Now you sit there!" He yelled out, "Now you've done it!" She said, "Done what?" he replied, "Busted both my balls." The mother became hysterical and ordered the receptionist to get the doctor quick. The crowded reception room was in an uproar.

As the doctor and his nurse approached the emergency, the little boy pulled a busted ping pong ball out of each hip pocket.

J. Morgan Kellum, M.D., F.A.C.S., F.I.C.S.
Thomasville, Ga. 30286

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STAFF:

BOAZ HARRIS, M.D., Medical Director
CONWAY HUNTER, JR., M.D., Director, Addictive Disease Unit
CHARLES D. STEWART, JR., M.D., Director, Adolescent Services
JOHN B. HARDMAN, M.D., Director, Children's Unit

ositive, comprehensive
hat's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is separately accredited by the Joint Commission on the Accreditation of Hospitals.

ete information or a personal tour of the facilities and explanation of programs, contact:

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DIMENHYDRINATE (Dramamine(	25mg

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MISCELLANEOUS

MORRIS' ANATOMY NEEDED. Late edition preferred. Please write edition date, condition and price. Robert E. Cato, M.D., 722 First Street, Macon, Ga. 31201. Telephone (912) 743-1456 ('47M Emory). *Please call collect* if you don't like to write.

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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ıe effectiveness of Valium (diazepam) in long-term use, that is, more than months, has not been assessed by systematic clinical studies. The ıysician should periodically reassess the usefulness of the drug for the dividual patient.

ontraindications: Tablets in children under 6 months of age; known persensitivity; acute narrow angle glaucoma; may be used in patients th open angle glaucoma who are receiving appropriate therapy.

arnings: As with most CNS-acting drugs, caution against hazardous oc- ıpations requiring complete mental alertness (*e.g.*, operating machinery, iving). Withdrawal symptoms (similar to those with barbiturates, alcohol) ıve occurred following abrupt discontinuance (convulsions, tremor,)dominal/muscle cramps, vomiting, sweating). Keep addiction-prone indi- duals (drug addicts or alcoholics) under careful surveillance because of edisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

TAL: Advise patients against simultaneous ingestion of alcohol and other NS depressants.

)t of value in treatment of psychotic patients; should not be employed in u of appropriate treatment. When using oral form adjunctively in convul- e disorders, possibility of increase in frequency and/or severity of grand al seizures may require increase in dosage of standard anticonvulsant edication; abrupt withdrawal in such cases may be associated with tem- rary increase in frequency and/or severity of seizures.

ECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local ation, swelling, and, rarely, vascular impairment when used I.V.: inject wly, taking at least one minute for each 5 mg (1 ml) given; do not use all veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra- erial administration or extravasation. Do not mix or dilute Valium with er solutions or drugs in syringe or infusion flask. If it is not feasible to minister Valium directly I.V., it may be injected slowly through the infusion ing as close as possible to the vein insertion.*

minister with extreme care to elderly, very ill, those with limited pulmo- y reserve because of possibility of apnea and/or cardiac arrest; con- nitant use of barbiturates, alcohol or other CNS depressants increases pression with increased risk of apnea; have resuscitative facilities avail- e. When used with narcotic analgesic eliminate or reduce narcotic dos- e at least 1/3, administer in small increments. Should not be administered patients in shock, coma, acute alcoholic intoxication with depression of al signs.

s precipitated tonic status epilepticus in patients treated for petit mal tus or petit mal variant status.

hdrawal symptoms (similar to those with barbiturates, alcohol) have oc- red following abrupt discontinuance (convulsions, tremor, abdominal/ scle cramps, vomiting, sweating). Keep addiction-prone individuals ier careful surveillance because of predisposition to habituation/ pendence. Not recommended for OB use.

cacy/safety not established in neonates (age 30 days or less); pro- ged CNS depression observed. In children, give slowly (up to 0.25 /kg over 3 minutes) to avoid apnea or prolonged somnolence; can be eated after 15 to 30 minutes. If no relief after third administration, propriate adjunctive therapy is recommended.

cautions: If combined with other psychotropics or anticonvulsants, efully consider individual pharmacologic effects—particularly with known npounds which may potentiate action of Valium (diazepam), *i.e.*, notHiazines, narcotics, barbiturates, MAO inhibitors and antidepres- ts. Protective measures indicated in highly anxious patients with ac- npanying depression who may have suicidal tendencies. Observe usual cautions in impaired hepatic function; avoid accumulation in patients compromised kidney function. Limit oral dosage to smallest effective ount in elderly and debilitated to preclude ataxia or oversedation (ini- y 2 to 2½ mg once or twice daily, increasing gradually as needed or trated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

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In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

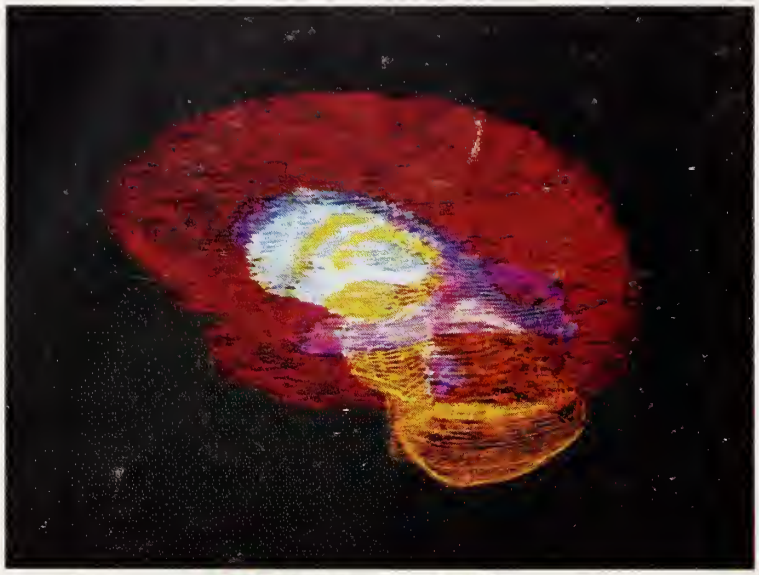
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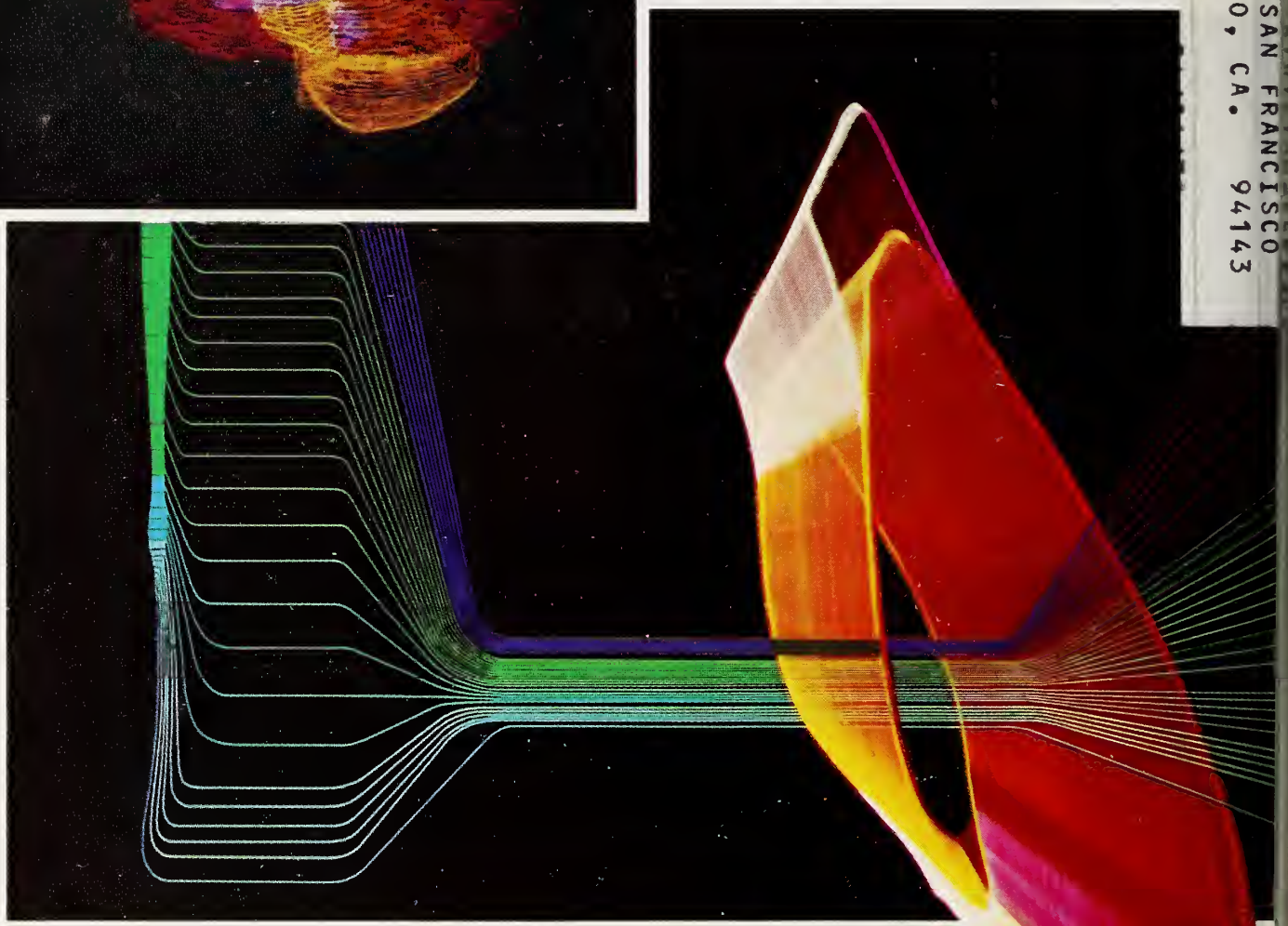


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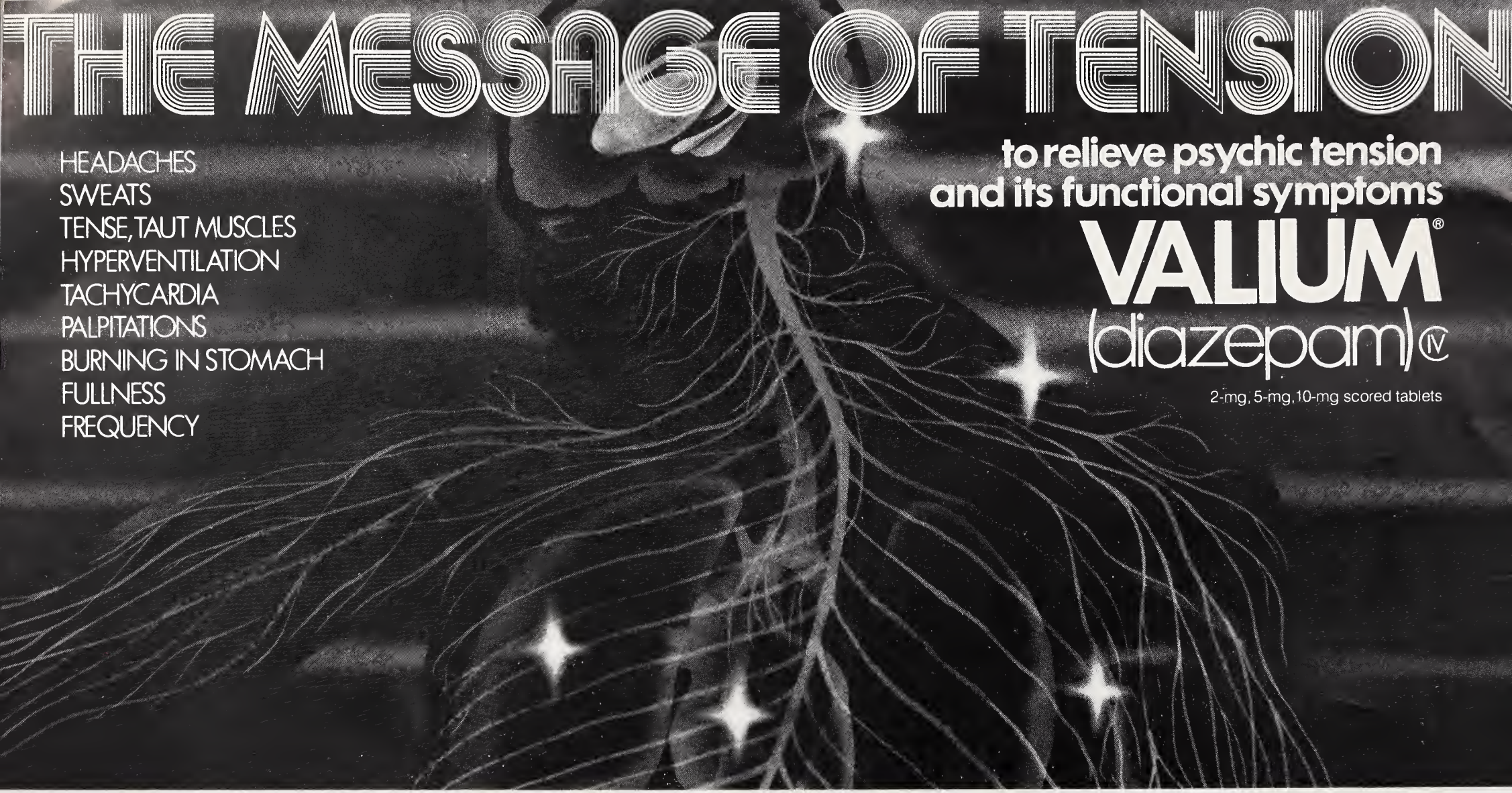


A revealing letter from an MAG member

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VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the indi-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predispos-

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

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Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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An especially well written letter was received recently from a member of MAG. Though he had been a member for a long time, he first became active in the House of Delegates this year. He found it to be an enlightening experience which gave him a new perspective on his Association. He shares his thoughts with you on page 624. Cover design by Bob Hamill.

MEDICAL MEETING CALENDAR

SEPTEMBER

8—*Atlanta;* **HEMODYNAMIC MONITORING IN ANESTHESIOLOGY;** Category 1 Credit; Contact: John T. Bonner, M.D., 80 Butler St., Atlanta 30303. PH: 404/588-4564.

7-9—*Atlanta;* **TUBERCULOSIS CONFERENCE;** Contact: William H. Foege, Center for Disease Control, U.S. Public Health Service, Building 2, Room 8-47, Atlanta 30333. Ph: 404/633-3311.

7-9—*Winston-Salem, NC;* **FAMILY MEDICINE;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27103.

8-9—*Wrightsville Beach, NC;* **ANNUAL MEETING OF THE NORTH CAROLINA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS AND THE NORTH CAROLINA PEDIATRIC SOCIETY;** Contact: David R. Williams, M.D., Southgate Shopping Center, Thomasville, NC 27360.

9-10—*Atlanta;* **MEDICO-LEGAL PROBLEMS AND ANESTHESIOLOGY;** Category 1 Credit; Contact: Z. W. Grambling, M.D., Georgia Society of Anesthesiologists, Medical College of Georgia, Augusta 30901.

11-12—*Chattanooga, TN;* **TENNESSEE VALLEY MEDICAL ASSEMBLY;** Contact: Jerome H. Abramson, M.D., 960 East 3rd St., Suite 313, Chattanooga, TN 37403.

12—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

13-15—*Durham, NC;* **ANGUS M. MCBRYDE PERINATAL SYMPOSIUM;** Contact: Angus M. McBryde Perinatal Symposium, Box 2967, DUMC, Durham, NC 27710.

14-15—*Gainesville, FL;* **FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM;** Contact: Howard W. Ramsey, M.D., P.O. Box 13494, Gainesville, FL 32604.

15-16—*Nashville, TN;* **NINTH ANNUAL PEDIATRIC SYMPOSIUM — RECENT ADVANCES IN THERAPY AND PREVENTION OF INFECTIOUS DISEASES;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, TN 37212. PH: 615/322-2716.

18-19—*Jacksonville, FL;* **CLINICAL FAMILY PLANNING FOR PHYSICIANS;** Contact: James A. O'Donnell, M.D., 655 West 8th St., Jacksonville, FL 32209.

21-22—*Nashville, TN;* **POSTGRADUATE COURSE IN ALLERGY;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, TN 37212. PH: 615-322-2716.

21-23—*Louisville, KY;* **GYNECOLOGIC SURGERY;** Contact: University of Louisville, Department of Ob-Gyn, Louisville, KY 40202.

21-23—*Williamsburg, VA;* **CARDIOLOGY FOR THE CLINICIAN;** Category 1 Credit; Contact: Tidewater Chapter, American Heart Association, 891 Norfolk Square, Norfolk, VA 23502.

21-23—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Contact: William C. McGarity, M.D., 1365 Clifton Rd., N.E., Atlanta 30322. PH: 404/321-0111.

25-26—*Jacksonville, FL;* **LAPAROSCOPY COURSE;** Contact: Robert J. Thompson, M.D., 655 West 8th St., Jacksonville, FL 32209.

25-28—*San Francisco, CA;* **AMERICAN ACADEMY OF FAMILY PHYSICIANS ANNUAL SCIENTIFIC ASSEMBLY;** Contact: AAFP, 1740 West 92nd St., Kansas City, MO 64114.

27-30—*Nashville, TN;* **SYMPOSIUM ON DIAGNOSTIC IMAGING;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, TN 37212. PH: 615/322-2716.

28-30—*Winston-Salem, NC;* **SEMINAR IN MEDICINE;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27103.

28-October 1—*Sea Island;* **PRIMARY CARE OF HAND INJURIES;** Category 1 Credit; Contact: Gail M. Gorman, American Society for Surgery of the Hand; 2600 South Parker Rd., Aurora, CO 80014. PH: 303/755-4588.

28-October 1—*Pinehurst, NC;* **UROLOGIC MALIGNANCIES;** Contact: Virginia Jordan, P.O. Box 3343, Duke Hospital, Durham, NC 27710.

29-30—*Orlando, FL;* **MEETING, AMERICAN SOCIETY OF INTERNAL MEDICINE;** Contact: W. R. Ramsey, 535 Central Tower Building, 703 Market St., San Francisco, CA 94103.

29-October 1—*Savannah;* **GEORGIA HEART ASSOCIATION, ANNUAL MEETING AND SCIENTIFIC SESSIONS;** Contact: Georgia Heart Association, 2581 Piedmont Rd., Atlanta 30324. PH: 404/261-2260.

30-October 3—*Hilton Head, SC;* **ANNUAL MEETING, SOUTHERN PSYCHIATRIC ASSOCIATION;** Contact: Annette S. Boutwell, SPA, P.O. Box 10387, Raleigh, NC 27605. PH: 919/821-2226.

OCTOBER

5-7—*Sea Island;* **ANNUAL MEETING, SOUTHEASTERN ALLERGY ASSOCIATION;** Contact: G. Frederick Hieber, SAA, 1401 Monticello Blvd., North, St. Petersburg, FL 33703. PH: 813/525-0861.

7-8—*Pine Mountain;* **GEORGIA GASTROENTEROLOGIC SOCIETY ANNUAL MEETING;** Contact: Joseph W. Griffin Jr., M.D., 212 Avondale Dr., Augusta, GA 30907. PH: 404/828-2238.

8-21—*Various Ports;* **GYNECOLOGY AND OBSTETRICS IN THE MEDITERRANEAN;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30322.

13—*Atlanta;* **SIXTH ANNUAL CARDIAC REHABILITATION SYMPOSIUM;** Contact: Gerald F. Fletcher, M.D., Director of Internal Medicine, 300 Boulevard, N.E., Atlanta 30312.

21-22—*Atlanta;* **MAGNET (MAG NEW EDUCATION TRAINING);** Contact: Ken Williams, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

NOVEMBER

11-14—*Atlanta;* **MAG-SOUTHERN MEDICAL ASSOCIATION SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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Dear MAG Member:

Read this and if you miss it, you deserve it.

Practice Productivity, Inc. (PPI) of Atlanta will join us again this year to cover two timely topics.

On the first day, PPI president, Bill McGrath, and PPI workshop instructor, Walt Disher, will examine one of our greatest concerns today - cost containment More specifically, Bill and Walt will attack the mutually shared problem of "FIGHTING INFLATION WHILE MAINTAINING QUALITY CARE." Costs can be controlled scientifically; however, an overview of the impact of inflation and a look at the necessary expenses precede his answer on how to do something about it.

A scrutinizing eye will be turned toward reducing collection costs while enhancing patient relationships. How? Practice Productivity spells it C-O-N-S-I-S-T-E-N-C-Y. The rewards of new collection techniques should spell S-U-C-C-E-S-S for us all. And the legal impact of the "Truth-In-Lending" laws concern one and all - whether we like it or not.

Indeed, insurance can be a nightmare for good collections - and for patients. Getting rid of paperwork may just go hand in hand with automating. PPI will look at these aspects of fighting inflation and more.

On the second day, Greg Gates, a PPI workshop instructor who is also a member of the State Bar of Georgia, deals with our inevitable, perhaps latent, concern: "WHAT TO DO WHEN THE DOCTOR DIES."

Greg's forthright inspection will encompass estates, wills, trusts, insurance and probate. The entire matter of selling the practice, handling patient records, and being an executor will be valuable and direct in approach. All too often, a physician leaves without giving his loved ones the necessary advice and tools to deal with the world ahead.

This is the outline for the MAGNET program 1978. We have designed this for you and your loved ones. This program invites you, your wife and your practice's key employees to participate in an exciting and educational conference.

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Sincerely yours,

Marvyn D Cohen, M.D.

Marvyn D. Cohen, M.D.
Chairman, Committee on Public Relations



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Letters to the Editor . . .

Dear Sir:

The President's Letter in the June issue of the *Journal* was taken from an address by Fairfield Goodale, M.D., dean of the School of Medicine, MCG, given at the school's June 1977 commencement.

A cover letter was apparently never received, giving appropriate credit to Dr. Goodale. He had given me permission to use part of his address entitled "Practical Cogitations."

Thank you for correcting this oversight.

Carson B. Burgstiner, M.D.
Savannah
President, MAG

Physicians' Assistants

Dear Sir:

With the letter I wrote to you in March, I attached a copy of the Georgia Association of Physicians Assistants (GAPA) position statement on the "Role of the Physician's Assistant in Relation to the Licensed Physician." I wish to clarify that the position statement was developed and approved by the GAPA Board of Directors September 17, 1977. In the editorial column of the May, 1978 *Journal of MAG* (vol. 67, page 343), the final paragraph (as edited) leaves the mistaken impression that the "position statement" is an official statement from the AMA.

I would appreciate your understanding and cooperation to correct this mistaken impression by perhaps allowing space in the next issue of the MAG *Journal* to indicate the "position statement" is not one from the AMA, but is an official statement from the GAPA. Permission would be granted to print the "statement" in its entirety if cited as official policy statement of the GAPA.

Thank you for your consideration and attention to this matter.

Alan B. Sams, P.A.-C.
President,
Georgia Association of Physicians' Assistants

Dear Sir:

This is in reply to the letter of Mr. Alan B. Sams, President of the Georgia Association of Physicians' Assistants, published in the May issue of the *Journal*.

For the record, I am all too familiar with what a physicians' assistant is, how he or she is trained, certified and utilized. I am also familiar with the stated policies of the Georgia Association of Physicians' Assistants. I am also acquainted with Mr. Sams personally and consider him sincere and dedicated.

It is Mr. Sams who has a basic lack of knowledge of how the federal government plans to use his group. The federal government has long since decided that it is not going to pay standard medical fees and is searching about for a method of providing cheap medical care under its programs. It is fact that the government is *already* using PAs *in lieu* of physicians in its hospitals to cut costs. They are planning to use the same everywhere possible if and when socialized medicine ("national health insurance") arrives.

It is a fact that these programs are mostly funded with taxpayers' monies collected by the federal government. It is also a fact that only 10% of the Emory University PA graduates are employed in the alledgedly "underserved" areas in rural Georgia.

It is my opinion that when a person pays for a physician's service, it should be rendered by a fully qualified physician. It is also my opinion that the contention that a person with *two* years training out of high school can render medical service of quality when a physician needs a minimum of *nine* years training to accomplish the same is erroneous.

Just how dedicated and sincere Mr. Sams may be is perhaps exemplified by a quote from the May 1978 issue of the Georgia Association of Physicians' Assistants' *Newsletter* which is signed by Mr. Sams as president.

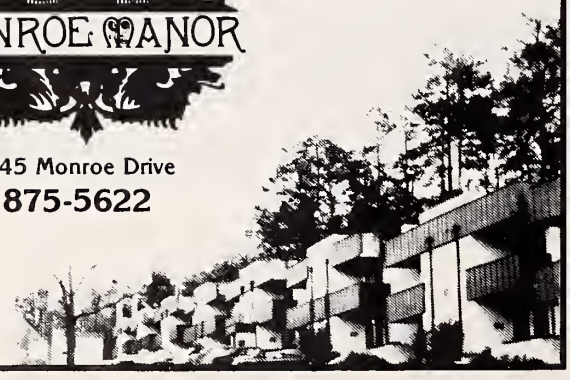
> "The PA's of Georgia have overcome the established political system, shown that the MAG and Medical Board do not necessarily represent quality medical care for Georgia's citizens, but pay only 'lip service' to quality. It is the physicians' assistants of Georgia who

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can assume their proper place in the health care delivery system by placing professional ability and the patient's welfare ahead of political convenience.''

I would ask the reader to re-study the preceding paragraph which speaks loudly and clearly and may give some insight into this many faceted problem as it evolves into deadly focus.

It is precisely our interest in quality medical care since the founding of the Medical Association of Georgia in 1849 which prompts the present posture of the Medical Association of Georgia House of Delegates on this problem. The Georgia Association of Physicians' Assistants has a pamphlet which it distributes entitled, ''Your Practice and the Physician's Assistant,'' which states that the average increase in a physician's income when employing a PA is $3,600.00 per annum. If money were our prime goal, then the posture of the House of Delegates would be in agreement with Mr. Sams.

Milton I. Johnson, M.D.
Macon
Immediate Past President, MAG

Reactions to June Issue

Dear Sir:

I appreciate the *Journal* of the Medical Association of Georgia dwelling on cancer of the breast. I think this is good. I thoroughly agree. I am enclosing a reprint of an article we wrote in *Cancer* recently. Anything like this will help. I appreciate it.

A. Hamblin Letton, M.D.
Atlanta

Dear Sir:

I must say that whoever conjured up the cover for the June issue on breast cancer must have subliminally remembered the classical sixty-four dollar question when the contestant was asked to name the Twin Peaks of California and responded ''Jane Russell!''

He was awarded the sixty-four dollars.

Sheldon B. Cohen, M.D.
Atlanta

Dear Sir:

As both a woman and a physician I must tell you how disappointed I was in the cover and its explanation in the June issue of the *Journal of the Medical Association of Georgia*. Not only did I find it distasteful, but I think the lay public will not appreciate such a hurmorless slant on this serious subject. A public display like this can only serve to hurt the important doctor-patient relationship. I trust this does not represent the attitude of our profession toward women or breast cancer.

Laura B. Powers, M.D.
D. A. Pelsier, M.D.
Decatur

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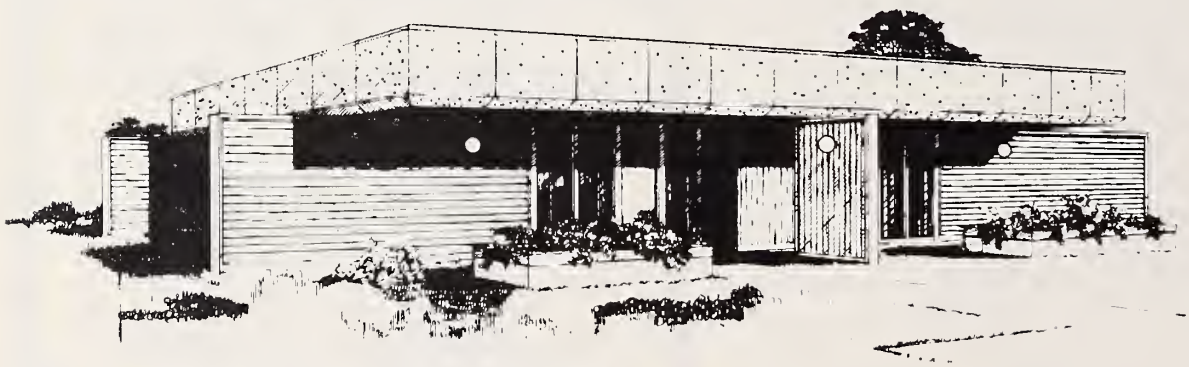
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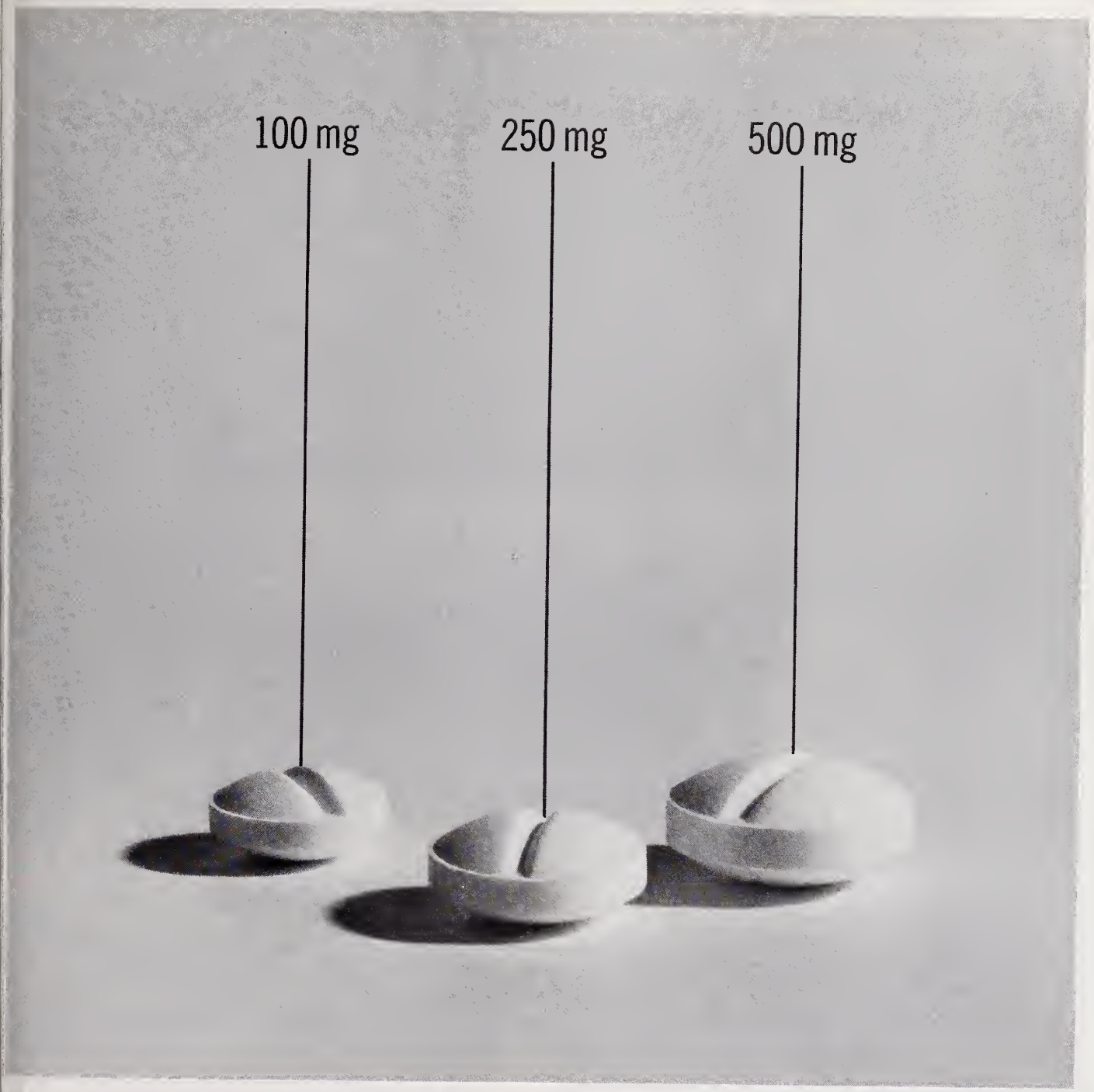
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Update on AMA

JOHN H. BUDD, M.D., *Cleveland, Ohio

WHEN SELECTING AND PREPARING material for this occasion, I decided to bring to your attention some of the issues and concerns which are attracting the most attention today and are important in their present and future impact on physicians, their quality of life, freedom, security, satisfaction and contentment. Extremely visible subjects right now are: health care costs; continuing medical education; health planning laws, and the perennial NHI.

Cost of Medical Care

Let's start with costs — cost effectiveness, containment — almost certainly the number one topic of the day most everywhere. For the steady, marked increase in costs is a matter of monumental concern. All segments of society are concerned, not only hospitals or the medical profession, but industry, labor, insurers, consumers. And all too obviously — and ominously — the federal government. You know how troubled the federal government is. So deeply in fact, that the White House is seeking cost control as the prime pre-condition for introduction of any form of national health insurance. In fact, cost is probably the strongest inhibitory influence against the adoption of any radical health insurance program.

The AMA is also greatly concerned. I can assure you of that. In addition to costs themselves, we are, of course, apprehensive over some of the measures proposed to control the increases. The anxiety is justified. Being faced with stringent repressive controls is more than a possibility — maybe even a probability.

Most of the plans, changes, regulations, systems and procedures suggested, which we so often find objectionable, arise out of concern over costs. PSRO, HMO, HSA, health planning law, NHI itself, FTC assaults on relative value studies, restriction of unlimited advertising by physicians, AMA participation in the accreditation of medical schools, of residency training programs, of certification of specialists. President Carter's hospital cost containment bill . . . all of them stem from this source.

Responding to this widespread concern and acknowledging that physicians do have a responsibility in the problem, AMA created and funded a National Commission on the Cost of Medical Care. It is important that besides doing all we can to moderate the rising costs of care we must resist — sensibly and reasonably — all *un*reasonable federal interference with our system of providing that care. We will oppose cost-cutting which might jeopardize the quality or restrict the availability of care.

The Commission is composed of individuals from many walks of life. It was assembled in 1975, started functioning in early 1976, and has worked nearly two years. Its final report is being printed now and will comprise three volumes. The summary has been widely circulated since December.

Costs *are* real. New technologies and new drugs that restore health and prolong life are expensive. Cost is also the expense of chronic illness that so often accompanies the extra years that medicine has added to human life. Diseases which formerly killed people, often quickly and inexpensively, now can often be managed even though still incurable. And life can be prolonged — at enormous cost.

Cost is also, partly, the upshot of greater demand for all kinds of health services stimulated by the very existence and growth of health insurance itself. Availability aug-

* Specialist in Family Practice and OB/Gun and immediate past president of the American Medical Association. This is the text of then President Budd's speech made at the President's Banquet, MAG Annual Session, April 15, 1978, at Jekyll Island.

ments demand and increases cost. The medicare experience was a lesson and awakened caution. Cost awareness has filtered through even to Congress, I believe, and discretion is likely to restrain rash action.

Besides these important factors, remember the effect of general inflation and the prices we must pay for what we need — including the staggering premiums for liability insurance. Let me give you an example of professional liability expense as a cost factor in medical practice. I have a personal physician friend in my own state, in a high risk specialty, who tells me his premium this year is $25,000, and that he works sixty hours per week. Assuming a fifty-week year (two weeks' vacation), this means 3,000 hours per year. At $25,000, his insurance comes to $8+ per hour.

Let me give you another little math exercise. You know that the Carter bill calls for limiting hospital cost increase to 9% per year. Now bankers, investment advisors, and my school teachers have told me that adding 9% per year to any number will double it in 8⅓ years. A pocket calculator will conform that. Thus, a hospital with per diem cost of $150 per day today will cost $300 per day in 8⅓ years, $600 per day in 16½ years, and $1,200 per day in 25 years.

"We are asking that the physician recognize his role as purchasing agent for the procedures which generate much of the costs."

Mind boggling figures, to be sure. And they are based on a 9% limit. Inflation often exceeds this, as do some of the wage increases sought and gained recently. This is the direction our economy is moving. And along with it goes the cost of everyting.

Now before we become guilt-ridden, I'd like to point out that the fiscal transgressions of hospitals — and doctors — so clamorously censured by our critics have been grossly exaggerated. It cannot be denied that high-quality care is high-cost care, regardless of the wishfull thinking of economists, consumerists, efficiency experts, health planners and legislators. (By the way, an economist has been defined as "one who knows more about money than the individual who has it," and it has also been said that if planners were put in charge of the Sahara Desert, there'd be a shortage of sand in three years.)

For most of the causes of rising costs are not inefficiency or intemperate extravagance on the part of the private sector; they are largely inevitable (and justifiable), such as wage rates and prices paid by hospitals, increased spending for improved services, added personnel, technological advances which were non-existent just two decades ago — open heart surgery, dialysis, organ transplants, major joint replacement, intensive care units for many varieties of life threatening illnesses.

So there is as much misinformation as reliable information being circulated regarding the facts behind rising costs — and more wishful thinking than wisdom in some of the proposed remedies, especially government-inspired remedies. It is cynical but pertinent to remind people that the government's track record — regardless of sincere effort — in controlling welfare abuse, inflation, crime, policies on Social Security taxation, Amtrak operation, postal service, is not impressive. A WAG has suggested that if left to the government, even crime would not pay.

The National Commission on Medical Care Costs consisted of 27 members and, as stated, they were from all the interested and involved segments of society. This mix was a guarantee that its conclusions would be provocative — in some cases controversial. Every segment represented will find proposals that will generate debate, to say the least. I believe though, that any reasonable person will agree that it is a thoughtful study, with recommendations for compromise to be considered by all, and I urge that there be sincere consideration of each recommendation.

Every physician who is an AMA member receives *Am News* and got a copy of the summary. I hope you all have or will read it. Remember, it is experiment that is proposed, not establishment. Please for sure underline and remember the word "recommendations."

As a part of the medical profession's responsibility in cost containment, we are asking that each physician recognize his role as purchasing agent for the procedures which generate much of the costs. I believe that education and information given to physicians on hospital rates and charges would be helpful. Doctors are not accustomed to thinking of cost, rather of what is best for the patient, and of course, the patient goes along with that. You have often heard the generous encouragement, "Spare no expense, Doctor. I have insurance."

Another effort toward curtailing cost increases is the voluntary 15-point program initiated by AMA-AHA-FAH, backed up insurance companies and the Chamber of Commerce. Their goals include a reduction of 2% a year in hospital price increases and a moratorium in bed construction. This came about in response to a challenge from Congressman Rostenkowski, chairman of the House Ways and Means Subcommittee on Health.

There is no doubt that the Cost Commission report and the voluntary restraint program have put us on the spot. Our necks are out. Government is pleased with the effort, but obviously skeptical of results. Rostenkowski, though he declined to support President Carter's 9% CAP bill, pending the voluntary effort, is waiting in the wings, armed with a bill to impose mandatory measures patterned after the Carter bill if the voluntary effort fails.

Continuing Medical Education

Another feature for the future for physicians is going to be continuation of the increasing emphasis on continuing medical education. A variety of reasons are apparent — the rapid development of new procedures, consequent swift obsolescence of older ones, challenges to professional competence in liability lawsuits, requirement for liability insurance eligibility, for specialty society membership, licensing authorities, etc.

It was many years before licensure to practice medicine was established and added to the simple requirement of a diploma from a medical school. Even now, only a majority, not all, of the states require an internship for licensure (just 35 of the 55 states and territories). And neither residency training or specialty board certification have been required. But continuing medical education is increasingly insisted on. Since 1971, when New Mexico became the first state licensing board to do so, some 23

states have passed legislation which enables the state board to establish continuing medical education as a requirement for physicians who wish to maintain a license in the state. In 16 of those 23, the regulations have actually been established, and in 13 of the 16, the AMA's Physician Recognition Award (PRA) is acceptable to meeting the requirement.

Some state medical associations require CME for membership (Oregon); some specialty boards demand it for continuance of certification; (Ob-Gyn); increasing numbers of specialty societies exact it for continued membership (AAFP). The "net" is snaring more and more and the pressure will continue to increase.

"It has been said that if (government) planners were put in charge of the Sahara Desert, there'd be a shortage of sand in three years."

Admittedly, there are questions and concerns — the relevance and effectiveness in maintaining or improving quality of care, impact on cost, do mandatory programs ignore or discriminate against the self-learning that many physicians take advantage of in their day-by-day activities, is the medical profession losing control of medical education to new non-medical elements such as government, insurance companies, hospital boards. It sometimes seems that physicians are more trusted and respected by patients than by legislators. Finally: is CME the biggest money game in town?

Like it or not, CME is here to stay. To ensure its quality, its relevance to practice, its availability, to protect against any "educator-entrepreneur" rip-off activity, there's need for an experienced, understanding, reasonable, non-federal organization to review, classify, coordinate and accredit programs and provide means of recording physician participation. AMA has that ability. The AMA-PRA, established many years ago, is accepted by numerous state licensing boards, and as of 1976, more than 60,000 physicians have received it. AMA has also separated the scientific assemblies from the House of Delegates meetings beginning with the interim session last December, and there will be 25 Regional CME sessions across the nation this year.

Health Planning Bill

With regard to government intrusion into the health care function, the health planning bill (92-641), is the most vivid recent example. I am sure that the "power of the people" was never more clearly demonstrated than by the storm of protesting letters to Congress over the guidelines published in the federal register. Congress was really startled. They have been relatively accustomed to criticism from organizations, but grass roots opinion had rarely, if ever, come in such volume and so emphatically. More than 55,000 letters from outraged individuals were received, and of course you know the guidelines were swiftly withdrawn.

A new revised set has been published. AMA has reviewed them, and our position is that, while an improvement in small degree over the previous set, they are still objectionable on numerous counts and we have so testified.

Principal objection is the mandatory approach, that all HSAs, for example, would be required to comply with the guidelines, which thus become standards, not guidelines. This, we believe, exceeds and probably contravenes Congressional intent. Congress has decreed local determination of need and we in AMA can support that. The fixed, mandatory short-term bed-population ratio of 4/1000 and the mandated percentage occupancy on a national basis ignores the unique, seasonal geographic, demographic characteristics of different communities.

National Health Insurance

And finally — what about national health insurance? Although it has been proposed and promised for 30 years, it is still in the bullpen, though maybe nearer getting a call than before. It heats and cools over the years as other issues pre-empt it (energy, inflation, etc.).

Mr. Carter, in his election campaign, declared it a number one priority item in his Administration, and he is being regularly prodded and reminded by Senator Kennedy and by Labor. However, he made a concomitant, incompatible pledge at the same time — a balanced budget by 1980. This creates a severe dilemma, I feel sure.

AMA's position of course is to favor the availability of equitable protection against the cost of illness through insurance which will keep the practice of medicine and the payment for medical services in the private sector, and we are unalterably opposed to any program in which the federal government would be given the responsibility for financing and administering a tax-payer-subsidized national health service such as the Kennedy-Corman Bill.

We have adopted a set of 17 principles which we believe essential to any countrywide insurance program. They are being heard and supported by an increasing number of academicians, politicians, economists and other segments of the public in general.

"Mr. Carter declared (NHI) a number one priority. . . . However he made a concomitant, incompatible pledge (of) a balanced budget by 1980. This creates a severe dilemma, I feel sure."

Will there be an NHI? Not in the next two years, in my opinion. A bill will likely be introduced, but hearings and debate will be the limit of action. Will fee-for-service survive? Yes.

The Future

This is a somewhat sketchy report on some of the factors I listed. There are many more — professional liability, relations with allied professions, FTC, modifications in the code of ethics, etc. If there are matters I have overlooked or covered poorly, I'll be glad to answer and comment further within the limits of my memory and intellect.

There are serious problems. Answers are incomplete. Be optimistic but not over-confident.

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A Challenge to My Fellow Physicians

MILTON I. JOHNSON, M.D., *Macon**

DR. BUDD IS A HARD ACT to follow!

My dear colleagues, nothing would please me more than to top off this delightful evening with a few pleasant platitudes to go with the delicious meal and the glow of warmth and fellowship that pervades this room.

Tomorrow you delegates will make the policy that directs the efforts of the Medical Association of Georgia under its new officers. Toward this end, I would respectfully beg your indulgence as I present a perspective for your consideration in your deliberations.

Gentlemen, whether we like it or not, we are engaged in a war! The course we take may very well determine whether our patients fall prey to the socialists who control our government who have squandered billions of dollars with policies that may well spell the doom of our civilization. We are going down the same path, blissfully ignoring the lessons of history.

When a government ceases to govern and assumes the role of a provider, the downhill spiral moves in its inexorable course to the destruction of the society involved.

The greatest danger that the American public faces today is the federal bureaucracy. They work in an insidious but easily recognizable pattern in consort with elected officials of leftist persuasion. First, they create a pseudo-problem which has a nidus of truth. They enlist the aid of the news media and the special interest groups and keep repeating the big lie until the public begins to believe that they must be telling the truth. In this instance, they claim that the finest medical care system that has ever existed on this earth, so recognized all over the globe, is grossly lacking. Then they promote a pseudo-solution, always involving the passage of restrictive laws administered by a horde of paper-shufflers and nit-pickers, paid for out of the public treasury.

When the pseudo-solution to the pseudo-problem fails, then a pseudo-solution to the failure is devised; the pattern is then repeated with more restrictive laws and regulations and more administrators, investigations and investigators. Throughout it all, they carefully set up a scape-goat so that the onus of failure will not fall on them.

Perhaps you may recognize this as a description of our situation when we tried to cooperate in the Medicare and Medicaid programs. None of this scenario should be news to you, the medical leaders of our state.

Sometimes organized medicine gets caught up in the naive reasoning that if it cooperates with the bureaucrats, the onus of the bureaucratic laws and regulations can be made more palatable. In almost every instance, that has proved to be faulty reasoning.

When we cooperate under the guise that if we don't, something worse will ensue, then something worse always ensues.

Our largest national medical organization is not without guilt in this respect.

These comments are in no wise made in an effort to be abrasive or to embarrass our distinguished guest here tonight, but to call attention to the fact that the Medical Association of Georgia is on record as being opposed to national health insurance. The AMA House of Delegates has twice caused to be introduced into the federal Congress a national health insurance bill. The MAG House of Delegates has twice stated opposition to this concept in any form.

A poll of the members of Congress revealed that only 2.4% of those responding agreed that the AMA must sponsor NHI legislation if it is to participate in the debate on the subject. The AMA has repeatedly refused to conduct a poll of its members on this subject, as requested by the MAG House of Delegates.

It is strange indeed that the AMA National Commission on the Cost of Medical Care worked 18 months looking for the causes of rising health care costs and did not find or mention in their report that the main cause of increased health care costs is *government deficit spending*, the main cause of the inflation which is destroying our country.

The voluntary hospital cost containment program of the American Hospital Association, the AMA and Federation of American Hospitals will probably not be very effective. Perhaps there is waste and inefficiency in hospitals, but it is miniscule compared to that of the federal government. Many publicly owned hospitals have excess employees, for example. The insurance industry is guilty of fueling this problem by writing grandiose non- or low-deductible health insurance policies. But the main reason for runaway hospital costs is simply government deficit spending

* Immediate past president of MAG. As president, Dr. Johnson delivered this speech at the President's Banquet, MAG Annual Session, April 15, 1978, at Jekyll Island. Dr. Johnson's address is 2605 Cherokee Ave., Macon, Ga. 31204.

which causes massive inflation. Until this is stopped, there will be no stabilization of cost of any item in our entire economy.

A very simple solution to the whole problem is to pass a law that forbids the federal government to spend more than 90% of its income each year and to apply the remaining 10% to reduction of the staggering national debt.

"Have you ever faced the possibility that your country could cease to exist?"

Coupled with this should be a provision that the federal government can pass no more tax revenue laws.

But the bureaucrats would recoil in horror in not having unlimited funds to manage all our citizens' lives while skimming off a pocketful for themselves.

Our own state association has also been remiss. We had the state asking us to back off in our Medicaid suit. They asked for a settlement out of court. Wiser heads than mine voted to settle and we got as a reward a bag with no bottom. The non-standard fees remain, the provider agreement remains. We paid $42,000 in legal fees for essentially nothing because we would not stand in the wind. We are now faced with the frightening spectre of the State going into the fee-for-service practice of medicine using nurse practitioners in the county health departments.

The MAG House of Delegates strongly opposed PSRO until it came down to the wire, and, receiving no help from AMA, caved in. Gentlemen, this law is nothing but a cost containment program with physicians as its pawns. Since it is not cost effective, even the federal bureaucrats now want to scrap it.

I would quote from Senator Kennedy's address to the AMA leadership conference in January: "No federally enacted medical 'solution' can be successful if it is resisted by the overwhelming majority of practicing physicians." To cooperate is to lose the battle, gentlemen. This last week he and the President combined forces and came to an "agreement" as to how to socialize medicine. This plan is scheduled to be introduced into the Congress this fall. How does this correlate with the President's State of the Union message which said, "Government cannot solve our problems. It cannot set our goals. Government cannot eliminate poverty or provide a bountiful economy, or save our cities, or cure illiteracy or provide energy. . . . We simply cannot be the managers of everything and everybody"?

It almost seems now that only the *individual* physician stands between the federal government and the destruction of quality medical care.

We must always keep in mind that *there is no right way to do a wrong thing, no correct way to do an incorrect thing and no honorable way to do a dishonorable thing.*

Have you ever faced the possibility that your country could cease to exist? Nations, richer and more powerful in their day then we are now, have been sabotaged, defeated, and enslaved. Babylon was the largest and richest nation of its time, but its lust for luxury made it an easy mark for the Medes and Persians who overran it, and divided its land and enslaved its people between them. Rome was a greater military power than we ever were, but when free bread and circuses became more important to the people than hard work and patriotism, Rome was invaded and looted by the tougher Vandals. The Incas were the most civilized, richest people in the Americas, but ruthless, better-armed invaders destroyed them as a nation, and looted everything they owned and had spent generations creating.

In modern times, the classic example of history repeating itself is Great Britain.

In every case, it was the self-indulgent weakness of the victim which caused its decline and decay.

How *strong* is a nation which allows foreign competitors to capture the world leadership from one after another of its most vital industries?

How *wise* is a nation which gives away so much of its substance abroad *and at home* that it can no longer afford to keep up its own strength and protection?

How *intelligent* is a nation more careful to protect the criminal than his victim?

How *weak* is a nation which allows bureaucracy and a socialist philosophy to run riot and squander billions?

History tells us that few democracies have survived more than 200 years. This being true, then what is in store for this nation of ours?

The process is always the same, a simple, vigorous people fighting for existence, acquiring luxury, becoming enervate and decadent: learning to live without labor, bartering its liberties for government largess, and finally passing from the grip of *domestic tyrants* into that of *foreign tyrants*.

Eternal vigilance is the price of liberty, and vigilance cannot be the quality of a people more interested in handouts than self-achievement. We must get away from easy thinking, easy living, socialism, and meaningless shibboleths.

Let us rise above personal considerations and do what needs to be done. We cannot accomplish this with so-called situation ethics and pragmatism. Let us work together. We must stop working at cross purposes. I call on the AMA to listen to the MAG House of Delegates: we oppose national health insurance; we do not like PSRO, and we want an all-member poll.

"Sometimes (we) get caught up in the naive reasoning that if we cooperate with the bureaucrats, the onus of the bureaucratic laws and regulations can be made more palatable."

I beg you to keep these thoughts in mind as you deliberate and cast your votes tomorrow.

In closing, I will say that all is not hopeless. As someone once said, "Nothing in the world can take the place of persistence. Talent will not; nothing is more common than unsuccessful men with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts.

"Persistence and determination alone are omnipotent."

I think that each of us owes a debt to the future inheritors of our noble profession. It is our obligation to leave the profession better than we found it. God give us the courage and strength to do it!



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†See Prescribing Information.

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See the complete Prescribing Information for this product, a summary of which is on the next page.

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IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product.

INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnancies Per 100 Women-Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen. **CONTRAINDICATIONS:** Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.

MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	D	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	D	C,D	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	D—Use associated with low risk.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT: (See Patient Package Insert). DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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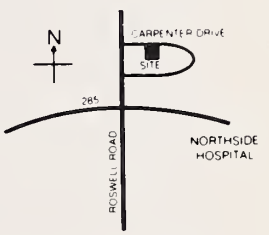
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An Open Letter . . .

May 5, 1978

Dr. Milton I. Johnson, Past President
Medical Association of Georgia
2605 Cherokee Avenue
Macon, Ga. 31204

Dear Dr. Johnson:

In April, I attended the annual convention of the Medical Association of Georgia as a first-time delegate. Prior to the convention, I was extremely skeptical of the ultimate value of our organization and especially of the possibility that real constructive action could be achieved in a rushed three-day convention.

Participation in the convention has made me aware of the vital constructive work done by our Association in many areas to promote the development of the best possible health delivery system for our citizens. The success of formulation of valuable positions taken after thorough consideration of numerous issues confronting the practice of medicine in three hard-working days was astounding to me.

I left Jekyll extremely proud to be a member of the Medical Association of Georgia.

If every Georgia physician could see the Association in action, I'm sure that the vast majority would want to work in the Association to preserve our private practice system and improve its imperfections which are constantly being decried and exaggerated in public primarily by persons who have little experience in health care delivery.

The valuable work of the Association could never have been achieved without officers and a House of Delegates of the highest caliber, who obviously have worked diligently throughout the year in the interest of the profession and ultimately in the interest of excellence of health care for all citizens. Accept my sincere appreciation for your hard work and for the excellent job done. I also recognize that little could have been accomplished without the hard work of many committees, the efficient work of the executive staff of the Association, the active constructive participation of the many component county medical societies, and ultimately the support of the vast majority of the practicing physicians of Georgia. My experience at Jekyll has made me feel a closer affinity to my fellow physicians who must share my strong conviction that we must preserve and improve our profession as a private institution. Proposals that have been made to create a federally financed or controlled system will ultimately result in a decrease in quality of care and potential bankruptcy of the nation (or its equivalent — soaring inflation).

I went to Jekyll convinced that the Association should mount an all out effort to block the unwise proposals of the health planners in Washington — essentially a negative approach which has been the primary thrust of organized medicine for many years and one that will probably continue to be only marginally effective. Since watching the work of the convention, I now strongly feel that the best defense against "socialized medicine" is the positive program of improvement in many areas supported by our organization. Most impressive and noteworthy among these positive steps are: (1) Strengthening of the peer review system and improvements in the Georgia Board of Medical Examiners with expanded emphasis on "quality control" of the practice of medicine. (It is obvious that *best quality* care can be provided only by trained physicians and not by expanded use of partially trained physician assistants or by the creation of a new and lower tier of medical care to be provided by nurse practitioners.); (2) Increased emphasis on continuing medical education for physicians and more complete and accurate medical information for the public; (3) Emphasis on cost control of medical care without sacrifice of quality; (4) Encouragement of programs that will provide adequate numbers of primary care physicians, provide more physicians to underserved areas, and facilitate entry of persons into our health care system; (5) Proposals to fill the gaps in health insurance coverage and to reduce health insurance costs by elimination of "first dollar coverage" and creation of a health insurance regulation agency to set standards that will avoid costly overcoverage of ordinary health care but encourage wider use of low-cost catastrophic health care coverage.

Again, accept my congratulation and appreciation for the diligent and most effective service that you have given in your position as president of the Medical Association of Georgia.

Sincerely,
R.L.J., M.D.

Dr. Johnson's reply

Dear Dr. J:

Thank you for your thoughtful letter of May 5, 1978 concerning The Medical Association of Georgia, and your generous personal remarks.

I am extremely impressed that your initial skepticism of the ultimate value of MAG was changed in such a short time to pride and enthusiasm by active, dynamic participation in medical politics.

Our organization is "US" and we make it what it is. If we had just 500 members who had your zeal and enthusiasm, think what we could do!

I would state to you that organized medicine has tried to cooperate with the Washington crowd and has ultimately lost almost every encounter by cooperating. We *should,* in my opinion, block them, but we *must* clean up our own house also.

Thanks for your interest, your participation, and for your thoughtfulness.

Please continue to stay involved and maybe we can still win the battle to preserve quality private medical care in America.

Most sincerely yours,
Milton I. Johnson, M.D.
Immediate Past President
Medical Association of Georgia

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GLOSSARY



A handy reference guide to common abbreviations used in organized medicine and government, compiled by the staff of MAG.

— A —

AAFP — American Academy of Family Physicians. One of the largest medical specialty societies; headquartered in Kansas City.

AAMC — Association of American Medical Colleges. Educational association composed of American and Canadian medical schools, teaching hospitals, and societies involved in medical education and research. Its purpose is the advancement of medical education and the nation's health. Publishes *Journal of Medical Education.*

ABMS — American Board of Medical Specialties. Nonprofit organization concerned with the establishment, maintenance and elevation of standards for the education and qualification of physicians recognized as specialists through the certification procedures of its 22 member specialty boards.

ACME — Alliance for Continuing Medical Education. A nonprofit corporation formed in 1975 with administrative assistance from the Miller and Fink Corporation (publishers of *Patient Care* magazine), to identify and promote implementation of a pluralistic, coordinated national system of CME.

ACP — American College of Physicians. One of two major national specialty societies for internists (the other being the American Society of Internal Medicine). The ACP has traditionally emphasized scientific education, while the ASIM has emphasized socioeconomic aspects of medicine.

AGMA — Atlanta Graduate Medical Assembly. Major scientific meeting held every spring in Atlanta and sponsored by the Medical Association of Atlanta.

AHA — American Hospital Association.

AHEC — Area Health Education Center. Generic term for a federally-funded regional program to provide training and continuing education for all health professionals. There is a network of AHECs in North Carolina but no AHEC in Georgia yet.

AHME — Association for Hospital Medical Education. National association of physicians and other individuals engaged in graduate and continuing medical education activities within community hospitals, founded in 1956; publishes a monthly newsletter and quarterly journal.

AIP — Annual Implementation Plan. Work program to implement the Health Systems Plan of the Health Systems Agencies.

AMA — American Medical Association.

AMA-ERF — American Medical Association Education and Research Foundation. Cooperative program of the AMA and several leading banks to guarantee loans to medical students, interns and residents; amount of loan is determined by need and the recommendation of the financial aid officer at the respective medical school. In 1977 the program loaned $7.3 million to over 5,000 students.

AMPAC — American Medical Political Action Committee. The political arm of AMA.

AMSA — American Medical Student Association. Organization of medical students originally founded by the AMA and now independent; it holds an annual convention and has a public foundation to provide students with non-traditional learning experiences and to lend assistance to medically underserved communities.

ASIM — American Society of Internal Medicine. (See ACP.)

— C —

CCME — Coordinating Council on Medical Education. A broadly constituted agency established in 1972 for the purpose of coordinating and supervising policy matters and accreditation at all levels of medical education; it includes representation from the AMA, ABMS, American Hospital Association, AAMC, CMSS, the general public and the federal government. Subsidiary agencies are: the Liaison Committee on Medical Education (LCME), since 1942 the official accrediting body for medical schools; the Liaison Committee on

Graduate Medical Education (LCGME), since 1975 the official accrediting body for residency training programs, and the Liaison Committee on Continuing Medical Education (LCCME), since 1977 the accrediting body for institutions and organizations offering CME programs.

CEU — Continuing Education Unit. A national system of rewarding and recording continuing education activities for nurses, allied health professionals, etc.; one CEU is equivalent to 10 contact hours of participation under responsible sponsorship, capable direction and qualified instruction; the state university system administers the program in Georgia.

CHAMPUS — Civilian Health and Medical Program of the Uniformed Services. Military medical insurance program.

CME — Continuing Medical Education. The final segment of a physician's lifetime program of learning; includes not only formal scientific meetings but a wide spectrum of activities from hospital committee work and consultation with colleagues to the reading of journals and use of videocassettes.

CMSS — Council of Medical Specialty Societies. Independent national federation of medical specialty societies; headquartered in Lake Forest, IL.

CON — Certificate of Need. In some states, the law requires hospitals to prove a need (by the community) before adding new facilities, beds or equipment. There has been some talk of extending this regulation to doctor's offices.

COTRANS — Coordinated Transfer System. A program for admitting foreign medical students to American medical schools with advanced standing; administered by the AAMC in cooperation with the National Board of Medical Examiners.

CPC — Clinical-Pathological Conference. A traditional form of continuing medical education in which a group of physicians reviews pathological findings for individual patient cases seen within the physicians' practice or institution.

CPT — Current Procedural Terminology. AMA-published book of the current procedure terminology used by physicians.

— D —

DEA — Drug Enforcement Administration.

DHR — Department of Human Resources (Georgia).

DMA — The Georgia Department of Medical Assistance. The Medicaid Agency for Georgia.

DPA — Designated Planning Agency. For state certificate of need and federal 1122 programs. The SHPDA serves in this capacity in Georgia.

— E —

ECFMG — Educational Commission for Foreign Medical Graduates. Organization established in 1957 to serve the public interest by administering a program of evaluation, examination and certification of foreign-educated physicians who desire to enter graduate medical education programs in the United States. To obtain certification, students must provide credentials of their education and pass a comprehensive examination and an English test.

EMT — Emergency Medical Technician. Allied health professional trained and certified to provide first-contact care for patients in emergency situations; as ambulance attendants they follow medical protocols and maintain communication with physician supervisors.

— F —

FACP — Fellow of the American College of Physicians. An internist and member of the ACP, distinguished for achievement in medical practice, research and education.

FACS — Fellow of the American College of Surgeons. A surgeon and member of the ACS, distinguished for achievement in medical practice, research and education.

FIFTH PATHWAY — An educational program to provide a year of supervised clinical experience for American students who have completed four years in a foreign medical school, so called because it is the most recently established of five ways by which foreign medical students or graduates may enter American medical education programs. A 1976 Georgia law mandates the program for the Medical College of Georgia.

FLEX — Federation Licensing Examination. An examination for medical school graduates, designed and administered by the National Board of Medical Examiners and usually required for medical licensure in a state.

FMG — Foreign Medical Graduate. The process by which graduates of foreign medical schools enter the United States is outlined in Public Law 94-484.

FSMB — Federation of State Medical Boards. National organization founded in 1912 to coordinate and assist the various state medical boards in overseeing the training and credentialing of physicians.

FTC — Federal Trade Commission. This agency has charged the AMA and some state medical associations with violation of anti-trust laws in regard to advertising and has been involved in "relative value studies."

— G —

GaMPAC — Georgia Medical Political Action Committee. The political arm of MAG.

GHA — Georgia Hospital Association.

GMCF — The Georgia Medical Care Foundation. A private nonprofit corporation founded by the MAG in 1970 to engage in medical peer review; the PSRO designee for the State of Georgia.

— H —

HCFA — Health Care Financing Administration. Medicare.

HEW — Health, Education and Welfare.

HMO — Health Maintenance Organization. An organization that provides medical care on a prepaid basis.

HPD — Health Planning and Development. Replaces the Comprehensive Health Planning Agency in accordance with Public Law 93-641.

HSA — Health System Agency. Agency established under Public Law 93-641 to establish health goals for the local health systems areas. There are six in Georgia, with the seventh being a part of Tennessee.

HSP — Health Systems Plan. Goals study of HSAs for community health and health systems.

— I —

IPA — Individual Practice Associations. Implementing HMOs.

— J —

JCAH — Joint Commission on Accreditation of Hospitals. An agency founded by the AMA, the American Hospital Association, the ACP and the American College of Surgeons to establish standards for the operation and services of hospitals and other health-related facilities. JCAH teams survey institutions on a voluntary basis, and certificates of accreditation are awarded to institutions in compliance with standards.

— L —

LCCME — Liaison Committee on CME. (See CCME.)

LCGME — Liaison Committee on Graduate Medical Education. (See CCME.)

LCME — Liaison Committee on Medical Education. (See CCME.)

— M —

M&I — Maternal and Infant.

MAFMC — Metropolitan Atlanta Foundation for Medical Care. The Foundation associated with the Medical Association of Atlanta; performs claims review for Medicare.

MAG — The Medical Association of Georgia. Serving the state's physicians for 128 years as their professional organization.

MAGNET — Medical Association of Georgia New Educational Training. An annual conference in its sixth year devoted to the business aspects of medical practice.

MECO — Medical Education and Community Orientation. A program initiated by the AMSA Foundation in 1969 to offer preclinical medical students the opportunity of working under supervision of a practicing physician for 4-10 weeks to gain first-hand knowledge of the health care system of a community.

MPH — Master of Public Health. Academic degree obtained by the specialist in public health or health education.

— N —

NAIC — National Association of Insurance Commissioners.

NHI — National Health Insurance. A concept which would provide health care benefits to persons not now covered, modifying the way in which those benefits are paid and reforming the current system of health care.

NHPRDA — National Health Planning, Research and Development Agency. The national agency over HSAs.

NHS — National Health Service. Federal agency established to recruit and help finance health professionals for medically underserved areas.

NJPC — National Joint Practice Commission. Organization founded by the AMA and the American Nurses' Association in 1972 to make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care. Supported by grants from the AMA, ANA and W. K. Kellogg Foundation, it represents the interest of the public rather than that of medicine and nursing per se. Many states, including Georgia, have affiliated statewide Joint Practice Committees, composed of an equal number of nurses and physicians.

NMAC — National Medical Audiovisual Center. Federally-funded institution, located at CDC in Atlanta, which provides comprehensive services in the design and production of medically-related instructional material.

NP — Nurse Practitioner. A registered nurse with preparation in a formal post-basic education program who, as a primary care provider, assesses the status of patients through history and physical examination, interprets the data, and develops and implements appropriate therapeutic action within the framework of a health care system.

— P —

PA — Professional Association. Legal structure for a business association of two or more physicians.

PA — Physician's Assistant. A person qualified by academic and practical training to work under the supervision of a responsible physician in collecting and organizing historical and physical data on patients and presenting them so that the physician can determine the appropriate diagnostic and therapeutic steps. The PA is also capable of educating patients, performing diagnostic and therapeutic procedures, and coordinating the roles of other health care assistants. In Georgia the PA must be certified by the Composite State Board of Medical Examiners under the provisions of the state Physician's Assistant Act.

PC — Professional Corporation. Legal structure for a business corporation of two or more physicians.

POMR — Problem-Oriented Medical Record. A system developed by Lawrence Weed, M.D., in the '60s in which all information in a medical record is linked to specific problems. The record has four sections: the defined data base; the complete problem list; plans, and progress notes. The system provides an organizing structure for all medical activities and is being used increasingly in hospitals, medical schools, and private practice.

PRA — Physician's Recognition Award. A voluntary program sponsored by the AMA in which physicians receive certificates for completing 150 hours of CME in a three-year period. At least 60 of the 150 hours must be in activities sponsored by organizations accredited for CME by the LCCME.

PSRO — Professional Standard Review Organization.

— S —

SERMLP — Southeastern Regional Medical Library Program. One of 11 regional medical library programs operating under contract with the National Library of Medicine to provide a nationwide network of access to and dissemination of health-sciences information in all its forms. SERMLP is headquartered at the A. W. Calhoun Medical Library at Emory University and serves Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee, and Puerto Rico.

SHCC — State Health Coordinating Council. Advisory council on implementing SHPDA.

SHPDA — State Health Planning and Development Agency. The state agency over HSAs.

SMA — Southern Medical Association. Professional medical organization founded in 1906 to promote the professional and personal advancement of its members. Its annual Scientific Assembly includes quality CME in all disciplines for physicians and other health professionals. Headquartered in Birmingham, it includes membership of over 23,000 from 17 southern states.

SOPHE — Society for Public Health Education. National professional and service organization founded in 1950 to promote and contribute to the advancement of the health of all people by encouraging study, improving practices, and elevating standards of achievement in the field of public health education.

— T —

TITLE 18 — Medicare.

TITLE 19 — Medicaid.

— U —

UCR — Usual, Customary and Reasonable.

UR — Utilization Review. A form of peer review focusing on the appropriate utilization of health care facilities and services for the purpose of third party reimbursement; includes such considerations as length of hospital stay and use of diagnostic and therapeutic procedures. JCAH standards require UR committees in hospitals.

— W —

WHO — World Health Organization.

Notes:

Got some additions to the list? Send them to the Journal.

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RICHARD B. STEWART, M.D., *Decatur

The Douglas Childbearing Center, also known as the Birthing Center or the Birthing Room, is part of a full-service obstetrical facility located in the Douglas General Hospital in Douglasville, Georgia, 20 miles west of downtown Atlanta. It was officially opened November 1, 1976.

The Center came into being as a result of a combination of factors. The first of these is my own commitment to the use of nurse midwives in my practice. When I left Americus, Georgia, in 1975, Dr. Schley Gatewood Sr. and I had practiced with two nurse midwives, using the team approach, for two years. I knew that I did not ever want to practice obstetrics again on any but a very limited scale without using this approach. I firmly believe that the best kind of delivery a woman can have is to be attended by a trained midwife, or a doctor who practices like a midwife. The trained midwife can recognize complications as well as an obstetrician, and she has the great advantage of remaining with the patient throughout labor.

So in Atlanta I made the rounds, looking for a hospital that would accept the idea of a nurse midwife working with me as a team. I did not find one.

Finally I located the Douglas General Hospital, which was willing to consider the idea. I started going out there one day a week in April 1976. Meanwhile, the word had gotten out around Atlanta that there was a doctor who believed in midwives, and I began to get invited to meetings of home birth groups, NAPPSAC groups, and childbirth education groups, where I was delighted to find a great interest in alternatives to present obstetrical care, including delivery by midwives.

The alternatives being sought by these women are principally those having to do with family-centered maternity care, and include having the husband or other support person present throughout labor and delivery, not being separated from the baby and the husband after delivery, unlimited rooming in, and permitting children and other family members to visit the postpartum unit. Many prefer to be delivered by a nurse midwife, and in December 1976 I employed Linda Goodman, a graduate of the University of Mississippi School of Nurse Midwifery.

Other alternatives not necessarily related to family-centered care includes:

* Decatur North Professional Building, Suite 601, 755 Columbia Dr., Decatur, Ga. 30030. This paper was presented before the Georgia Ob/Gyn society in Palm Beach, Florida, in December 1977.

1. no routine procedures such as prep, enema, or IV fluids unless indicated;

2. labor and delivery in the same bed without transfer to a table where stirrups and straps and flat-on-the-back position are required;

3. no silver nitrate drops in the baby's eyes until there has been eye-to-eye contact for some time as advocated by Klaus and Kennell;

4. early discharge.

Perhaps the most fortuitous circumstances of all then came into play as plans for a Birthing Room offering all the above alternatives proceeded rapidly between April and November. When the obstetrical unit at Douglas General was built, two large, well-equipped delivery rooms were installed, but only one small labor room. No one seems to know the reason for this, but it worked out just perfectly to take the delivery table out of one delivery room, install a regular bed, a few rugs, a bedside table and lamp, and a few wall hangings—in short, to create a bedroom-like atmosphere (except for the tile walls!). In addition, there is the installed oxygen, suction, mounted blood pressure apparatus, scrub sink and utility area. The small nursery is located across the hall.

Personnel was the other important factor, and for those who might be contemplating a set-up similar to this I would emphasize that it is probably the most important factor. We had a number of applications from excellent nurses who were looking for this type opportunity, so from the beginning we have had no disgruntled, unhappy nurses or aides walking around mumbling under their breath about "all these crazy, newfangled ideas." You can have the nicest facilities in the world available for family-centered care, only to have the whole atmosphere ruined by one person who walks into the area with an opposing spirit.

I cannot say enough in praise of our nurses, some of whom are childbirth educators, and all of whom know what is taught in CEA, Bradley and LaMaze classes well enough to act as support persons if the patient and/or her husband start to lose control of the situation.

In November we had five deliveries; in December, three; in January, seven. By the end of one full year we had had exactly two hundred.

One infant death took place at the Medical Center in Macon, Georgia, over a month following delivery. After it became apparent that this patient would need a Cesarean section because of premature rupture of membranes and failure to progress in labor with IV pitocin, the Angel II team at Grady Memorial Hospital was alerted in accordance with previous arrangements we had made with them to transport any of our sick infants. During the Cesarean section, the team had to answer another emergency call, and by the time they arrived the only bed available was in Macon, Georgia. The infant was operated on at a little over two weeks of age for patent ductus and died two weeks after surgery.

Because of this, we decided in the future to transfer all mothers *before* delivery if there seemed to be a good chance that the infant might be in trouble.

One such transfer was done when a mother presented in active labor, five centimeters dilated, with gestional age between 25-26 weeks. The infant was double footling breech. My partner, Asher Galloway, accompanied this patient to Grady Memorial Hospital where she elected to buck the odds and have a Cesarean section. The infant weighed 490 grams and is alive and apparently well at home today, thanks to super care given in the Grady Memorial Hospital Neonatal Intensive Care Unit. We feel that it also helped that this mother came every day for months to the nursery to pump her breast and give the milk to the baby.

"As of July 1, 1978, there has been a total of 502 deliveries at the Center."

One other such case was that of a gravida three, Rh-sensitized mother who had amniocentesis twice in our facility. When her titers began to rise and her spectrophotometry showed her nearing the danger zone, she was transferred to Grady for possible intrauterine transfusion. She made it to 34 weeks without the intrauterine transfusion and was delivered of a live baby which did well after extrauterine exchange transfusion.

We feel that this has been a proper utilization of the concept of regionalization.

A word about follow-up of our infants. Since most mothers go home in less than 12 hours after delivery, we make every effort to know who their private pediatrician is and to see that they have the infant seen by him within 48 hours after discharge. We have identified the few groups of pediatricians in the Atlanta area who are comfortable with this arrangement and they have been very helpful to us also. Ninety-five percent of our mothers breastfeed, and the support of the pediatrician is indispensable. Of the six babies admitted elsewhere after discharge, five were for hyperbilirubinemia, one of whom was exchanged for ABO incompatibility. The other infant had slight pneumonitis which also gave an elevated bilirubin.

All mothers on discharge take with them a slip of paper with the results of the cord blood type, Rh, hematocrit, Coombs and bilirubin.

These are most of the elementary scientific facts. I

would now like to make a few remarks about the non-scientific facts.

I stated as my primary conviction that attendance by a trained midwife is the optimum care that a woman can receive in labor. My second conviction is that the psychological and emotional factors in labor and delivery are at least as important, if not more so, than the medical factors. That is a conviction, not a proven scientific fact. It will probably never be proven as a scientific fact, since psychology and emotion are hard to put on graph paper.

But one thing is a fact. Women in fast increasing numbers are demanding to be heard, and respected, and treated individually. In the field of obstetrics, since it involves the most important event in a woman's life, giving birth, all the movements now gaining momentum—the feminist movement, consumerism, the revolt against the overuse of technology, dehumanization and impersonalization by hospitals, and the return to nature and natural processes—are coming to a head.

Take the home birth movement. You may oppose it vehemently, but this movement, as one example of all the above, is here to stay. I get letters from doctors who send the records of patients transferring to me which state, "Since this lady has decided to have her baby at home, I have told her I do not offer this service and advised her to seek help elsewhere."

What service? Home delivery? I don't do home deliveries either, and neither does the nurse midwife employed by me. The patient is asking for prenatal care. When she and her husband come to me for the initial consultation I talk a long time with them to explore their reasons for wanting home birth. I explain that we have an alternative that offers the warmth and comfort of home, with the added safety factor. In spite of this, some still decide to deliver at home. In my mind, that puts them at increased risk, and it behooves me to see them even more often for prenatal visits to pick up the least little thing that may go wrong.

If I do this—if I say, "I think you may be doing the wrong thing, but I respect your right to assume for yourself all this responsibility, and I will give you meticulous prenatal care"—then if anything does go wrong, when I suggest that they need an in-hospital delivery, they comply immediately.

If I send them away in a huff with some put down about their foolishness, I not only reinforce their negative attitude about cold, insensitive doctors, but I have given them an attitude that may make them stay at home in a critical situation way past the point at which they should call for help. No one likes to hear "I told you so," even when she is bleeding to death.

A number of hospitals in the Atlanta area are fast making arrangements for alternatives in labor and delivery and postpartum areas. This makes me very happy, because I feel deeply that what women are asking for today is not a whim or fad, but something they and the infant need.

The studies on maternal-infant bonding are proliferating, and I have to agree with one observer at a conference dealing with this subject who said, "Never have I seen such overwhelming and convincing scientific evidence for something so perfectly obvious."

I invite all of you to take a long and serious look at nurse midwives, alternatives in labor and delivery, and the establishment of such facilities in your institution. Even if you are not philosophically committed to the ideas, but just trying to "keep up with the competition," I think in the end you will be happily pleased at what you discover.

DOUGLAS CHILDBEARING CENTER

Nov. 1, 1976-Nov. 1, 1977

Total no. of deliveries	200
Total delivered in birthing room	167
Age of mother	
19 and under	10 (5%)
20-24	90 (45%)
25-29	64 (32%)
30-34	24 (12%)
over 35-	12 (6%)
Gravida	
1	61 (30.5%)
2	84 (42%)
3	29 (15.5%)
4 or more	26 (13%)
Hours in labor	
0-4	39 (19.5%)
4-8	91 (45.5%)
8-12	49 (24.5%)
over 12	21 (10.5%)
Hours postpartum to discharge	
0-6	28 (14%)
6-12	114 (57%)
over 12	58 (29%)
Episiotomy	66 (33%)
Laceration	45 (22.5%)
Postpartum hemorrhage	14 (7%)
needing transfusion	5 (2.5%)
Forceps deliveries	10 (5%)
Paracervical blocks	13 (6.5%)
Saddle blocks	10 (5%)
Pts. on fetal monitor	24 (12%)
Uncomplicated vertex deliveries	174 (87%)
Breech	7 (3.5%)
Twins	4 (2%)
Cesarean sections	15 (7.5%)
Repeat	4
Primary	11 (5.5%)
CPD	5
Failure to progress	2
Breech	2
PRM, failed induction	1
Transverse lie	1
Patients transferred before delivery	2 (2 live births)
Babies transferred after delivery	5 (1 set twins)
Babies known to have been admitted elsewhere in first month of life	6
Perinatal deaths	1 (5/1,000)
Previous C-sections delivered vaginally	2

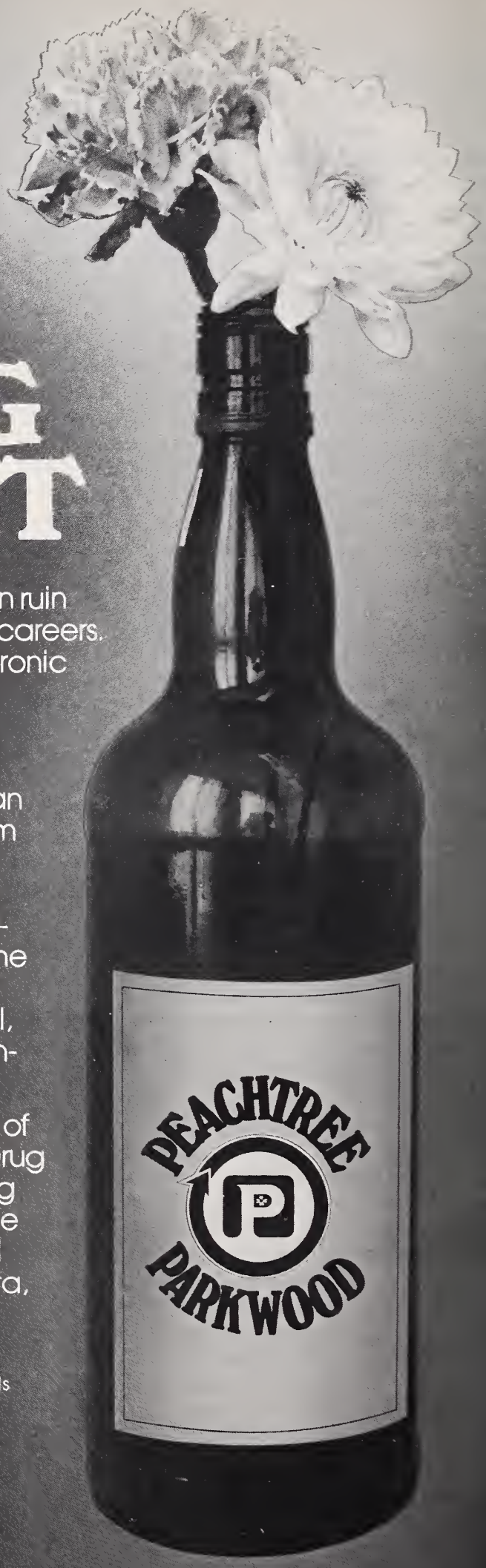
A SOBERING THOUGHT

Alcohol and other addictive drugs can ruin physical and mental health, families and careers. Because alcoholism is a complicated, chronic disease of the mind, body and spirit, the alcoholic is unable to overcome his or her problem alone.

Using a highly structured treatment plan — individualized for each patient — a team of physicians, nurses, alcohol/drug counselors and activity therapists at Peachtree and Parkwood's Alcohol and Drug Addiction Unit works with the patient to unravel the physical and emotional complications of chemical addiction. The Plan: withdrawal, individualized treatment and aftercare under close medical supervision.

Complete information on the services of Peachtree and Parkwood's Alcohol and Drug Addiction Unit may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

Accredited by the Joint Commission on Accreditation of Hospitals



Since a considerable proportion of physicians' earnings is allocated to insurance, the author's discussion should prove useful.

Life Insurance Buying

STUART SCHWARZSCHILD, Ph.D., *Atlanta**

PROFESSIONAL PERSONS ARE A TARGET GROUP for life insurance, real estate and security salesmen. One important reason for this is that professional persons as a group have sufficient discretionary income and sufficient accumulated wealth to make significant purchases. This article discusses how professionals can make more efficient life insurance buying decisions.

The life insurance purchase is complicated by many factors. Many companies pay policyholder dividends; therefore the gross premium is not a good measure of the annual cost. The dividends change from year to year and this fact, along with the changing cash values, greatly complicates the analysis. Even if it were possible to say that it was best to buy an ordinary life or a five-year renewable term policy, companies vary so greatly that analyses of each company's policies is also necessary. Frequently a company may have a very good product at one age but not be as competitive with the same policy at another age.

Interest Adjusted Method

One poor technique of determining an efficient policy, which unfortunately has been recommended by the industry and government agencies, is the Interest Adjusted Method. This technique is certainly better than the worse Surrender Net Cost Method which has been the traditional cost analysis technique. However, the Interest Adjusted Method is not useful in choosing between a cash value policy and a term policy, or between a high cash value policy and a low cash value policy. The reason the Interest Adjusted Method is not valid is that different types of policies provide different amounts of pure protection *even though the face amounts of the two policies may be the same*. The Interest Adjusted Method does not take into consideration the net amount at risk. Obviously, a $50,000 ordinary life policy, if kept for 20 years and which has a 20th year cash value of $20,000 (and net amount at risk of $30,000) has not provided $50,000 of pure protection over the 20-year period, whereas, a $50,000 five-year renewable term policy would have provided $50,000 of pure protection each year. The Interest Adjusted Cost Indexes of these two policies should not be compared because this would be comparing the cost of $50,000 of protection with the cost of less than $50,000 of protection.

Also, the Interest Adjusted Index, as used by the industry and regulatory agencies, only shows the results at the end of a 10-year or 20-year period. Not only should the buyer be interested in results at other durations, but results at these decennial periods may not be accurate measures of the results at the end of other periods. It is easy for companies to skew their dividend scales and cash values so as to achieve

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TABLE I

AAA MUTUAL LIFE INSURANCE COMPANY
MONETARY ADVANTAGE ON A YEAR-BY-YEAR BASIS
OF BUYING TERM AND INVESTING THE DIFFERENCE
AT 7½% IN LIEU OF $100,000 ORDINARY
LIFE AT AGE 35

(1) Year	(2) Investment Income Tax Sheltered	(3) Investment Income Taxed at 40%
1	1359.38	1321.02
2	2790.47	2670.97
3	2833.70	2586.05
4	2755.98	2328.60
5	2734.50	2070.84
6	2621.43	1663.87
7	2590.98	1276.11
8	2649.82	907.72
9	2810.15	563.90
10	3078.99	244.00
11	3467.63	–50.82
12	3980.89	–318.47
13	4629.83	–557.34
14	5429.67	–762.30
15	6395.18	–929.65
16	5341.14	–3285.32
17	6271.44	–3805.59
18	7403.72	–4286.78
19	8757.23	–4724.55
20	10226.10	–5240.78

TABLE II

BBB MUTUAL LIFE INSURANCE COMPANY
MONETARY ADVANTAGE ON A YEAR BY YEAR BASIS
OF BUYING TERM AND INVESTING THE DIFFERENCE
AT 7½% IN LIEU OF $100,000 ORDINARY
LIFE AT AGE 35

(1) Year	(2) Investment Income Tax Sheltered	(3) Investment Income Taxed at 40%
1	1708.00	1660.33
2	3174.04	3024.78
3	3267.82	2955.60
4	3374.37	2830.92
5	3598.50	2748.80
6	3800.28	2563.35
7	4136.02	2423.02
8	4616.22	2329.86
9	5153.20	2187.03
10	5760.04	1997.64
11	6814.21	2124.61
12	7910.58	2159.50
13	9055.20	2097.30
14	10454.60	2132.76
15	11920.70	2065.30
16	13285.60	1676.42
17	14832.70	1270.77
18	16574.60	844.92
19	18524.90	395.22
20	20598.40	–182.15

favorable index readings at decennial periods, when the results at other periods would not have been as favorable.

Linton Method

A technique of analysis which is very understandable and meaningful is to measure how much better off or worse off one is by buying one policy as compared with another. This technique was originally used by a famous actuary, the late M. Albert Linton. The Linton Method assumes that the money saved by buying the lower priced policy could be put in a Savings and Loan Association or government bonds or could be used to pay off the mortgage or other debts, etc. In other words, the savings have an interest income value. Of course the interest income may be taxable, but if placed in a tax-exempt vehicle like municipal bonds, Individual Retirement Account or qualified compensation plan, it would be nontaxable. The following discussion uses the Linton Method for a person who wishes to increase his death estate $100,000 by either buying $100,000 of whole life or by buying term and investing the difference.

AAA Mutual. The policies illustrated here are for a person age 35 who is considering whether to purchase from the AAA Mutual Life Insurance Company a $100,000 ordinary life policy or a five-year renewable term policy. Assume he purchases the five-year renewable term policy: he has to pay less, and therefore he can invest the difference. As his investment fund grows, his expenditure for term insurance can be reduced. In order to have the same estate as the whole life policy would have provided, as his investment fund grows he needs less and less term. Column 2 of Table I reflects the annual results if he invests the money saved by buying the term at 7½% in a tax-free vehicle like an Individual Retirement Account (IRA), Qualified Pension Plan (QP), Municipal Bond (MB) or Tax Sheltered Annuity (TSA).

Scientific and effective techniques should be used in analyzing a life insurance purchase.

As one can see in Column 2 of Table I, he is ahead the first year by the sum of $1,359.38 if he buys term insurance and invests the difference. The second year he is $2,709.47 better off with the term and investment program. By the end of the 20th year, he is $10,226.10 better off than he would be if he had put the same amount of money in an ordinary life, and his estate would have the same amount at his

TABLE III

20 YEAR ILLUSTRATION OF EFFECT OF BUYING TERM AND INVESTING THE DIFFERENCE AT 7½% IN A TAX EXEMPT INVESTMENT*

(1) Year	(2) Ordinary Life Payment	(3) Term Life Coverage	(4) Term Life Payment	(5) Difference Between W.L. and Term Payments	(6) Investment Fund End of Year	(7) Gain (Loss) Buying Term & Investing
1	2203.00	97797.10	614.17	1588.83	1708.00	1708.00
2	2203.00	96089.10	603.44	1599.56	3555.62	3174.04
3	2035.00	94222.90	591.72	1443.28	5574.20	3267.82
4	2011.00	92229.10	579.20	1431.80	7730.99	3374.37
5	1961.00	90122.60	565.97	1395.03	10009.70	3598.50
6	1907.00	87898.50	610.89	1296.11	12352.40	3800.28
7	1854.00	85596.60	594.90	1259.10	14844.00	4136.02
8	1799.00	83160.90	577.97	1221.03	17480.60	4616.22
9	1744.00	80580.70	560.04	1183.96	20273.60	5153.20
10	1690.00	77843.80	541.01	1148.99	23236.30	5760.04
11	1636.00	74936.90	696.16	939.84	26194.40	6814.21
12	1531.00	72082.70	669.65	861.35	29291.10	7910.58
13	1430.00	69086.40	641.81	788.19	32542.10	9055.20
14	1324.00	65941.80	612.60	711.40	35954.00	10454.60
15	1213.00	62642.50	581.95	631.05	39533.80	11920.70
16	1102.00	59176.30	810.12	291.88	43014.60	13285.60
17	987.00	55811.40	764.06	222.94	46681.40	14832.70
18	869.00	52264.40	715.50	153.50	50546.70	16574.60
19	749.00	48522.50	664.27	84.73	54624.30	18524.90
20	627.00	44572.10	610.19	16.81	58929.00	20598.40

* Company used was a large eastern mutual life insurance company re $100,000 ordinary life at age 35.

death with either the ordinary life or the term and investment fund.

If the investment income had been subject to income taxes at the 40% rate, then the results are shown in Column 3. His first year gain would have been $1,321.02 instead of $1,359.38 and his second year gain with the term and invest the difference would have been $2,670.97, instead of $2,790.47. The income tax effect is more significant as time goes on, so that he is only ahead with term insurance and investment for the first ten years. By the end of the 20th year, the income tax effect is such as to make him better off with the ordinary life by the sum of $5,240.78.

As you can see, the analysis is sensitive to the rate being earned *net of income tax*. If he had invested at a taxable 9½% he would have been ahead with the term and investment program *regardless of whether or not income was subject to tax*.

Table I reflects the annual advantage of buying term and investing the difference at 7½% relating to buying ordinary life from a large Eastern life insurance company.

Another Company. But in order to see what happens when one changes companies, Table II reflects the results if instead you had used another Eastern life insurance company (the BBB Mutual Life Insurance Company).

Since this BBB's ordinary life policy is not as good a buy as the AAA's, you are even better off buying term and investing the difference with BBB. Buying term and investing the difference with BBB produced *twice as big* an investment fund when the investment was tax free, and even when taxable at 40%, buying term and investing at 7½% was ahead for 19 of the 20 years.

Readers who are interested in a somewhat more detailed illustration of the analysis are referred to Table III.

Summary

Professionals are a prime target for life insurance. They should use scientific and efficient techniques for their life insurance purchase decision. Failure to do so is costly just as the failure to use professional and efficient techniques in their own professional practice can be costly. The industry-endorsed Interest Adjusted Method is only useful in judging between policies with similar cash value schedules. Even so, it is not a reliable index for all policy durations. The Rate of Return methodology on a year-by-year basis is more meaningful and gives you, the buyer, better decision guidance. Buyers who desire to make efficient decisions need to analyze the results for different companies and policies.

Bronchoscopy should be carried out in most patients to rule out underlying malignancy, relieve obstruction, establish drainage and obtain suitable culture material.

Lung Abscess

BASHIR A. CHAUDHARY, M.D., *Augusta**

A LUNG ABSCESS is a circumscribed area of suppurative inflammation of the lung parenchyma with central necrosis and cavitation. Lung abscesses communicate with the bronchial tree, and with drainage of the suppurative material an air fluid level develops, leading to the "classical" roentgenographic picture. The etiology of lung abscess, aspiration pneumonia and necrotizing pneumonia (with multiple small abscesses) is similar, and results from aspiration of materials or organisms into the tracheobronchial tree.

A primary lung abscess, then, is caused by aspiration of bacteria-laden secretions from the oropharynx. Aspiration is common and occurs even in healthy subjects during sleep;[1] however, the normal lung defense mechanisms rapidly clear the bacteria, and no infection results.[2] In healthy subjects, with no evidence of gingivo-dental disease, anaerobic bacteria outnumber aerobic bacteria by a ratio of 10:1;[3] that is, "life on man" is mainly anaerobic. In the presence of dental disease, the total number of anaerobic bacteria and their relative proportion to aerobic bacteria is increased. In recent years, because of greater recognition and the availability of anaerobic culture techniques, the role of anaerobic bacteria in the causation of lung abscess is well established. The organisms most frequently isolated from lung abscess are listed in Table 1. Anaerobic bacteria are present in more than 90% of the cases of primary lung abscess.[4] In about half of the cases, anaerobic bacteria are the only isolates. In about one-third to one-half of cases, aerobic and anaerobic bacteria are present. Lung abscess due to aerobic bacteria alone is relatively uncommon (less than 10%).

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The factors which predispose to lung abscess are summarized in Table 2. Poor dental hygiene and an altered level of consciousness are present in a majority of the patients. Young children and the very elderly rarely develop primary abscess because severe caries and gingival disease occur infrequently in the former, and the very elderly are likely to be edentulous. Lung abscesses occurring in edentulous patients are usually associated with bronchogenic carcinoma. Another important factor in the etiology of lung abscesses is esophageal disease.

Primary lung abscesses usually occur in the dependent zones of the lung, following aspiration of oropharyngeal secretions.[5] About two-thirds occur on the right side, because the right main bronchus is a direct continuation of the trachea. In the supine position, the superior segments of the lower lobes are in the most dependent position. If a slight turn is taken to one side, then the upper lobe bronchi are in the most dependent positions and aspirated material goes to posterior segment of the upper lobe. About 85% of lung abscesses occur in these segments on either side.[6] If aspiration occurs in the sitting position, the basal segments of the lower lobe are the most dependent segments. This used to be a common site of lung abscess developing after dental extraction.

Patients with lung abscess usually present with a one- to three-week history of respiratory and constitutional symptoms. In the early stages, the clinical features are difficult to differentiate from pneumonia. Usually within four to six days, the pneumonic process undergoes necrosis and ruptures into a bronchus. At this time, cough becomes severe and copious amounts of purulent sputum are produced. Putrid sputum is a hallmark of anaerobic infection, as aerobic bacteria rarely causes this characteristic penetrating odor. The putrid discharge tends to occur

a few days after the onset of the episode, probably reflecting a large concentration of anaerobic bacteria. The incidence of putrid odor varies depending how early patients come under observation and was present in 76% of Barnett's[6] patients and 47% of Bartlett's[7] patients with lung abscess. Lung abscess may rupture into the pleural space causing empyema.

Physical examination of chest usually reveals signs of consolidation and/or cavitation. Leukocytosis is common occurring in 89% of Bartlett's[7] series; however, the patient may have a normal leukocyte count. In Barnett's[6] series, less than half of the patients with lung abscess had leukocytosis more than 10,000/cu mm. Leukopenia is a poor prognostic sign. Anemia is usually present, suggesting the indolent nature of the disease. A chest roentgenogram confirms the presence of a cavitary lesion, and the involvement of dependent segments of the lung suggests an aspirational etiology.

The possible causes of cavitary lung disease are listed in Table 3. Cavitation in pneumococcal pneumonia is very rare. Staphylococci, Klebsiella, Pseudomonas and other gram negative aerobic organisms may cause a lung abscess. The initial Gram's stain of sputum, cultures and absence of putrid odor will help in diagnosis of such cases. Additionally, fungal disease must be ruled out. In cases of cavitary tuberculosis, the initial PPD and sputum examination for acid fast bacilli may be negative. Thus, repeated sputum examination for acid-fast bacilli should be done until clear evidence of etiology of lung abscess is determined.

Embolic abscesses may occur in septic thrombophlebitis. These usually originate from the veins of the lower extremities or from indwelling catheters. The abscesses which occur following septic emboli are usually small, multiple and located in the subpleural zones of the lung. Anaerobic bacteria are usually involved if the septic emboli originate in the pelvic veins. Staphylococci are often responsible for infections from indwelling catheters. Infection, with subsequent development of an air fluid level in a cystic lesion of the lung, such as an emphysematous bulla, may be difficult to differentiate from a primary lung abscess. The most important clues are the presence of emphysematous changes and bullae in other parts of the lung and less consolidation in the surrounding lung parenchyma. Comparison with a previous chest radiograph may be helpful. The patient is usually less sick than might be expected from the chest roentgenogram. Parasitic infections causing lung abscess are relatively rare in this country.

Both primary and secondary tumors may cavitate. Squamous cell carcinoma is particularly likely to do so. In one study[8] cavitation was noted in 22% of cases with this cell-type. The wall of the cavity

TABLE 1

COMMONLY CULTURED ORGANISMS IN PRIMARY LUNG ABSCESS

Anaerobic (present in 95%)	
Cocci	Peptostreptococcus
	Peptococcus
	Microaerophilic Streptococcus
Gram negative bacilli	Fusobacteria
	Bacteroides Melaninogenicus
	Bacteroides Fragilis
Gram positive bacilli	Eubacteria
	Propionibacterium Species
Aerobic and Faculatative Aerobic (Present in 25-40%, generally with anaerobes)	
Cocci	Diplococcus Pneumonia
	Streptococci
	Staphylococci
Bacilli	Klebsiella
	Pseudomonas
	Escherchia Coli
	H. Influenzae

TABLE 2

PREDISPOSING FACTORS

1. Altered Level of Consciousness
   a) alcoholism
   b) drug overdose
   c) epilepsy
   d) recent anaesthetic
   e) cerebrovascular accidents
   f) miscellaneous
2. Oral Inflammation
   a) Gingival disease
   b) Dental infections
   c) Tonsillectomy
3. Esophageal/Gastric Diseases
4. Pulmonary Conditions
   a) Carcinoma
   b) Bronchiectasis
   c) Tuberculosis
   d) Other

TABLE 3

CAUSES OF CAVITARY LUNG DISEASE

Infections

Primary lung abscess
Lung abscess due to aerobic organisms
Tuberculosis/fungi
Septic emboli or infarction
Infected cystic lesions of lung
(Emphysematous bullae, traumatic cysts, bronchiectatic cysts, loculated hydropneumothorax, bronchogenic cyst)
Parasitic infections
(Entaemaeba, Echinococcus, Paragonomus)

Tumors

Primary (usually squamous cell CA)
Secondary

Collagen and Vascular Diseases

Rheumatoid nodules with necrosis
Vasculitis (Wegener's Granulomatosis)
Pulmonary infarction with cavitation

consists of tumor rather than granulation tissue, and is generally thickened and irregular; however, an occasional tumor cavity may be thin-walled. The eccentricity of the cavity and the presence of multiple holes have been said to be suggestive of carcinoma. Bronchoscopy and sputum cytology is of value in the differential diagnosis.

Rheumatoid nodules may become necrotic and cavitate simulating an abscess. They are usually multiple in number, and the patient will have signs and symptoms of rheumatoid arthritis in most cases. An area of pulmonary infarction may cavitate because of ischemic necrosis or may become infected by bacteria from the airways and cavitate. Many diseases causing a vasculitis, such as Wegener's granulomatosis, may have nodules and cavitate.

In the differential diagnosis of cavitary lung lesions, a history of aspiration, the presence of gingivo-dental disease, and/or a putrid odor to the sputum suggests a primary lung abscess. Gram's stain of the sputum usually reveals multiple organism, both gram-negative and gram-positive. If the initial Gram's stain and culture of sputum identifies only one type of bacteria, then the culture may be valuable. However, in general, the culture of expectorated sputum in the bacteriological diagnosis of lung abscess is not helpful, because the sputum is contaminated by oropharyngeal bacteria. Aerobic and anaerobic cultures of a transtracheal aspirate, prior to beginning antibiotic therapy is the most useful bacteriological study. The value of repeated culture of expectorated sputum for follow-up during the course of antibiotic therapy is questionable because most hospitalized patients become colonized by gram-negative bacteria. If reliance is placed on culture of the expectorated sputum alone, the results will be misleading in the majority of patients.[7] If associated emphyema is present, culture of the pleural fluid provides a valuable uncontaminated source which may be helpful in establishing a definitive bacteriological diagnosis.

Drainage of the pus is crucial in the management of lung abscess and is often neglected. Postural drainage aided by percussion of the chest is a cornerstone of treatment and should be employed as often as necessary. If adequate drainage is not established, therapeutic bronchoscopy may be helpful.

Antibiotics have greatly changed the clinical picture and prognosis of the lung abscess. Penicillin, which is effective against most anaerobic bacteria, is the drug of choice. In toxic patients penicillin is usually employed intravenously, beginning with high doses (six to twelve million units), and continued for one to three weeks, until there is clinical improvement. At this time, an oral penicillin may be substituted, however, treatment should be continued until radiographic clearance or stabilization has been achieved, which usually takes eight to twelve weeks. An important point to realize is that it takes some time before any improvement in patient's status is evident. In one study,[10] one half of the patients were still febrile at the end of one week of therapy, the cavity had not closed in one-half of the patients at the end of a month and the radiographic clearance in half of the patients had not occurred at the end of two months of therapy. Weiss, et al.,[12] in a prospective study, compared oral with parenteral penicillin in the treatment of acute nonspecific lung abscess and concluded that orally administered penicillin in a dosage of 3 g per day was just as effective as parenteral penicillin.

Bacteroides fragilis is found in 10-20% of patients with lung abscess, usually with other anaerobic bacteria. This organism is considered usually resistant to penicillin. However, response to penicillin treatment is no different if this bacteria is present, indicating a minimal contribution to pathogenesis, or inhibition of this organism by high concentrations of penicillin.

The therapeutic efficacy of clindamycin is similar to penicillin. Bartlett,[10] et al., compared the two drugs in treatment of aspiration pneumonia and primary lung abscess and found no difference between the two agents in terms of time required for defervescence, roentgenographic clearing and ultimate outcome. However, because colitis may develop in up to 10% of patients treated with clindamycin, penicillin is the preferred drug, clindamycin being reserved for patients in whom penicillin is contraindicated. Carbenicillin[12] and metronidazole have also been used with good results. No prospective clinical studies are as yet available with the cephalosporins.

The role of aerobic gram-negative bacteria in mixed aerobic and anaerobic lung abscess is not clear. Response to penicillin in patients with mixed infection has been similar to those in which only anaerobic bacteria have been present. In hospitalized patients the upper airways are soon colonized with aerobic gram-negative bacteria, hence, the bacteriology is different in hospital-acquired aspiration as compared to community-acquired aspiration.[13] In such circumstances the aerobic gram-negative bacteria may dominate and penicillin or clindamycin with the addition of one of the aminoglycosides (e.g. gentamicin) should be considered.

Chloramphenicol has excellent antibacterial activity against the bacteria causing lung abscess including Bacteroides fragilis. However, due to its well known toxicity it is rarely used in the management of primary lung abscess, except under extenuating circumstances.

Bronchoscopy should be performed in most patients with lung abscess to rule out underlying malignancy, and to relieve obstruction and establish drainage. Bronchoscopy may also be useful in obtaining

material for culture. The role of surgery is limited chiefly to drainage of empyema. External drainage of an abscess cavity, lobectomy or pneumonectomy which were frequently employed in the past, are now rarely indicated.

The prognosis of lung abscess has vastly improved since the introduction of antibiotics. In the pre-antibiotic era one-third of the patients died from primary lung abscess, one-third had a persistent chronic course and/or radiographic abnormality, and only one-third resolved completely. Now the vast majority of patients with primary lung abscess recover. Deaths are usually due to associated or underlying conditions. Massive hemoptysis associated with lung abscess may herald a fatal outcome, and is an indication for emergency consideration of resectional surgery. Resolution of a lung abscess may be slow if the abscess is large, if therapy is delayed and in elderly patients, alcoholics and patients with underlying chronic obstructive lung disease.

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Heart Association Plans Annual Meeting, Scientific Sessions

The Georgia Heart Association's 30th Annual Meeting and Scientific Sessions will be Friday through Sunday, Sept. 29-Oct. 1 at the Savannah Inn and Country Club in Savannah.

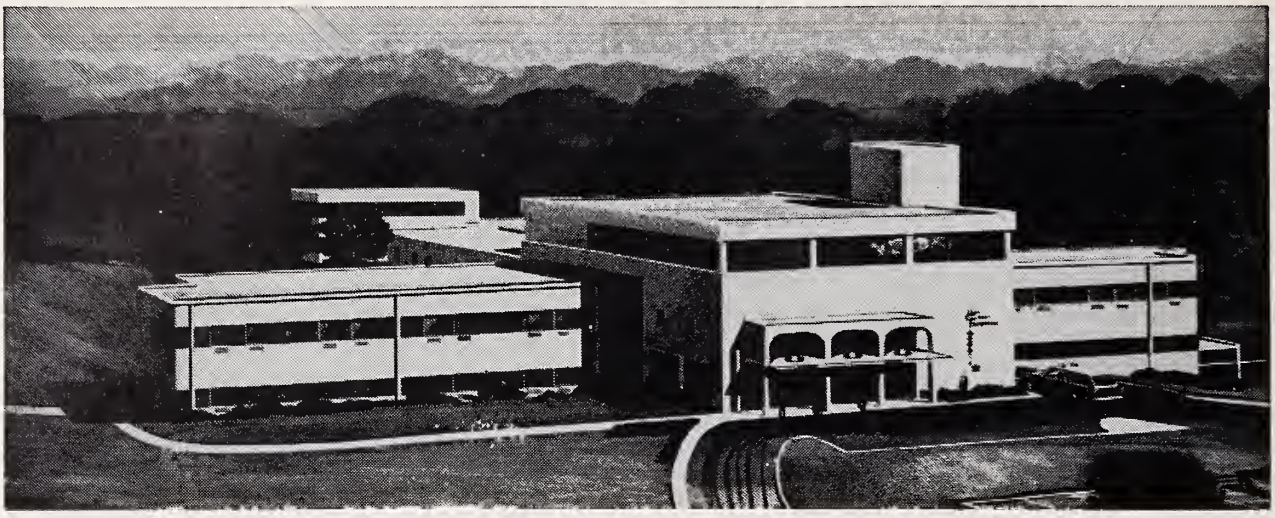
Scheduled events include the Annual Meeting Luncheon, a General Session for all Heart volunteers and Scientific Sessions for physicians, nurses, dietitians and nutritionists. The meeting will honor R. Bruce Logue, M.D. of Atlanta, founding president of GHA. One of the nation's outstanding cardiologists, Dr. Logue is professor of medicine at Emory University School of Medicine, where the R. Bruce Logue Chair of Cardiology was established by the Emory Board of Trustees earlier this year.

GHA Past Presidents will be honored at the Annual Meeting Luncheon during which Nanette K. Wenger, M.D. of Atlanta will preside as current president of GHA, and Joseph M. Turner, M.D. of Tifton will be installed as president for 1978-79.

Scientific sessions for physicians will begin Friday morning and continue through Noon Sunday. Featured speakers will be: Ellis L. Jones, M.D., Atlanta, "Coronary By-Pass Surgery—Present Successes"; William C. Roberts, M.D., Bethesda, Md., "Coronary Heart Disease—Fact and Fancy"; Albert A. Kattus, M.D., Los Angeles, Cal., "Prinzmetal Vasospastic Angina—A Concept"; Barry L. Zaret, M.D., New Haven, Conn., "Radioisotopic Evaluation of Cardiac Performance" and "Radioisotopic Evaluation of Myocardial Perfusion and Viability"; and Spencer B. King, III, M.D., Atlanta, "Coronary Angiography in Patients with Recent Myocardial Infarction."

A special symposium co-sponsored by the American Heart Association's Council on thrombosis will be presented Sunday morning featuring Sol Sherry, M.D., Philadelphia; Nanette K. Wenger, M.D., Atlanta; and Arthur Sasahara, M.D., West Roxbury, Mass.

Registration information is available from the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, Georgia 30324.



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The Use of Prostaglandin E_2 Vaginal Suppository in Missed Abortion, Intrauterine Death and Hydatidiform Mole

L. RAUL TAKAGI, M.D., F.A.C.O.G., *Riverdale*, EDWARD A. GULLING, M.D., *Chicago, Illinois, and* JAMES A. O'LEARY, M.D., F.A.C.O.G., *Mobile, Alabama**

THE DIAGNOSIS AND MANAGEMENT of missed abortion, intrauterine fetal death and hydatidiform mole has been the subject of revision in recent years. With the use of ultrasound, X rays, HCG determinations and increased clinical awareness, early and accurate diagnosis of these disorders is often made.

The treatment of missed abortion and intrauterine fetal death usually has been that of watchful expectancy. However, procrastination may eventually lead to coagulopathies, while delay certainly contributes greatly to patient anguish.[6-8] Medical induction with oxytocin is frequently a prolonged and unsuccessful venture. The other modalities, such as intraamniotic instillation of hypertonic saline and abdominal hysterotomy are associated with increased morbidity and complications. The use of dilation and curettage is somewhat limited since it is a relatively safe procedure only when the uterus is less than 12 weeks size.[4] The treatment of hydatidiform mole offers similar problems, but in addition requires immediate initiation of therapy.

The purpose of this study is to evaluate the usefulness of Prostaglandin E_2 (The Upjohn Company, Kalamazoo, Michigan) Vaginal Suppositories in the management of these disorders of pregnancy.

Materials and Methods

The patients in this study were admitted to the Foster G. McGraw Hospital-Loyola University Medical Center during the period of January 1974 through June 1977.

There were 12 cases of missed abortion where the uterine size was 14 to 18 weeks, 25 cases of intrauterine fetal death where the uterine size was from 22 to 32 weeks gestation, and 6 cases of hydatidiform mole where the uterine size was from 16 to 20 weeks. The diagnosis was confirmed in each instance by ultrasound, X ray, and HCG titers. No patient with a uterine scar was admitted into the study.

Maternal ages ranged from 19 to 39 years, gravidity varied from 1 to 8, and the uterine size from 14 to 32 weeks. It is of interest to note that 34 patients were referrals to our medical center and that all of them had had at least two days of oxytocin stimulation prior to their transfer. In all of the 43 patients in the study the Bishop cervical score was rated poor.[2]

All the patients were admitted to the hospital the day prior to initiation of therapy, routine baseline laboratory studies were obtained and a type and cross-match was performed. Clotting studies were evaluated in all patients with a fetal demise or missed abortion. All patients were kept NPO that evening and an enema was given before the transfer to the labor room the next morning. Baseline vital signs were recorded and an intravenous infusion of dextrose and water was administered through a large plastic catheter.

The patients were placed in the lithotomy position, a speculum was introduced into the vagina, and under direct vision, the posterior fornix was dried. A 20 mg. Prostaglandin E_2 Vaginal Suppository was placed in the posterior fornix and the patients kept in the supine position.

A suppository was re-inserted every 2 to 2½ hours unless a normal contraction pattern had developed.

The patient's vital signs were repeated at 15-minute intervals, and side effects were recorded appropriately. Analgesia and sedation were administered as necessary. Anti-emetics were liberally employed to control nausea and vomiting.

A dilation and curettage was performed on the three cases of hydatidiform mole after the expulsion of the molar tissue and in two of the missed abortion because of retained placental tissue.

Results

There were no failures in this study. The number of patients is small; however, considering the very

* Formerly from the Department of Obstetrics and Gynecology, Loyola University Stritch School of Medicine and Foster G. McGaw Hospital, Maywood, Illinois. Dr. Takagi's address is Clayton Professional Building, 33 S.W. Upper Riverdale Rd., Riverdale, Ga. 30274. This paper was supported in part by a grant from The Upjohn Company.

poor cervical scores, the results seem promising.

The induction time varied from 1½ to 22 hours (one case) with a mean of seven hours.

The total dosage of Prostaglandin E_2 Vaginal Suppositories ranged from 20 mg. to 200 mg. and the mean dosage given was 60 mg. The side effects most commonly observed are associated with the gastrointestinal tract.[1, 5] Thirty patients experienced nausea and vomiting, while 23 patients had one or more episodes of diarrhea.

A temperature elevation was observed in 12 patients, with the highest elevation being 104 in one patient.

A decrease in the blood pressure was observed in 15 patients. The average drop was 20 mm. of Hg in systolic and/or diastolic blood pressure.

Hypertonus of the uterus has not been clearly defined. If a contraction lasts longer than two minutes it is considered hypertonic. The phenomenon was not observed in any of our patients. However, coupling of uterine contractions was a frequent observation.

Discussion

The uterus is relatively insensitive to oxytocin in the second trimester but becomes more responsive as term approaches. Turnbull and Anderson[9] have shown that there is usually a progressive ripening of the cervix, while Hillier has shown a definite rise in the amniotic fluid concentration of prostaglandin F between the second trimester and delivery.[3, 9] It seems logical to assume that the endogenous prostaglandin activity may play a role in preparing the uterus and softening the cervix. Therefore, it may be more logical to use prostaglandins rather than oxytocin to induce labor when the cervix is very unfavorable.

At the present time there is no evidence to encourage the abandonment of oxytocin as the routine agent for labor induction, especially in light of the significant incidence of maternal side effects encountered with prostaglandin therapy. However, PGE_2 may well be a more efficient agent where the cervix is highly unfavorable. This drug may also be safer in those clinical situations where the potentially antidiuretic property of oxytocin should be avoided, especially in severe pre-eclampsia and cardiac disease. It may also be preferable in those cases where the fetus is more susceptible to hyperbilirubinemia.

An intravaginal route does offer certain advantages over other available therapeutic methods, especially in the management of missed abortion. The intraamniotic route in such cases subjects the patients to the hazards of the technic of amniocentesis and also to the risk of infection, which in these patients is potentially significant. Oxytocin infusions in high concentrations have generally produced poor results in the management of missed abortion. In our experience, intravaginal PGE_2 combined with premedication with antiemetics offers a simple, safe and reliable means of terminating these pregnancies.

At the present time, abortion between 12 and 16 weeks of gestation poses some technical problems. Suction or curettage at this stage of pregnancy is associated with increased incidence of uterine perforations, hemorrhage, cervical tears, and incomplete emptying of the uterus. Amniocentesis for instillation of prostaglandin or hypertonic saline is easier and safer after 16 weeks of gestation. Therefore, the availability of the intravaginal route for terminating pregnancy during this period of gestation is highly desirable. In this study, those patients between 12 and 16 weeks pregnant, the pregnancy was successfully terminated in every case using intravaginal PGE_2.

Transient erythema has been observed at the site of intravenous prostaglandin infusions. No patient complained of vaginitis and speculum examination prior to discharge from the hospital was uniformly normal.

Blood loss greater than 250 cc. occurred in only one case of a hydatidiform mole and amounted to 500 cc.

Upon termination of therapy, vital signs returned to normal values and no patients experienced residual side effects. There was no postpartum morbidity or complications. Prophylactic antibiotics were not employed.

All patients were discharged home within 48 hours in good condition and on follow-up all the patients are doing well.

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Early recognition and treatment is essential for survival of the patient in this uncommon condition.

Intragastric Rupture of a Left Gastric Artery Aneurysm

Report of a case and review of the literature

RONALD ISAACSON, M.D., *and* HERMAN DELANCY, M.D., *Savannah**

THERE ARE MULTIPLE CAUSES of massive upper gastrointestinal hemorrhage. Our purpose is to report a case of massive gastrointestinal hemorrhage caused by intraluminal rupture of a left gastric artery aneurysm. Upper gastrointestinal series, gastroscopy and arteriography are usually helpful in making the diagnosis. Early treatment is essential for increasing survival of patients with these difficult problems.

Case Report

A fifty-year-old male, foreign service officer, developed sudden onset of hematemesis, melena, and became shocky while stationed in Thailand. At that time the patient gave a history of having intermittent indigestion for approximately 20 years. He was transfused, and the bleeding stopped spontaneously. Gastrointestinal series revealed what was interpreted as a lesser curvature ulcer and a hiatus hernia. The patient experienced no further difficulty until some four months later, in mid-January of 1976, when he began to have marked symptoms of reflux peptic esophagitis. He was hospitalized at Memorial Medical Center in Savannah, Georgia, for evaluation. Gastrointestinal series revealed a large hiatus hernia without ulceration. Endoscopy revealed peptic esophagitis with a soft stricture, but no evidence of gastric ulceration was noted.

Four months later, because of failure of his symptoms to respond to medical treatment and because of his body build, a transthoracic Belsey repair of his hiatal hernia was carried out. His postoperative course was entirely benign and he was discharged from the hospital on April 26, 1976. The next day, the patient presented at the office with profound weakness. Hematocrit of 30 was obtained. Gastric aspirate revealed old clot, and there was dark stool in the rectum. The patient was rehospitalized and the next day the endoscopist reported a small esophageal ulcer with pooling of fresh blood in the fundus of the stomach which looked arterial in nature. The evening of endoscopy, the patient began to gag and wretch again. A nasogastric tube was passed and a large amount of clot was obtained. He was transfused and non-operative measures were attempted. The bleeding stopped for several days. However he had another episode of bleeding on May 4, 1976, requiring eight units of blood over a one-and-one-half hour period to maintain his blood pressure. He was taken to surgery, and a high gastrotomy revealed vigorous arterial bleeding from what appeared to be a large ulcer high on the lesser curvature and near the esophagogastric junction. This was oversewn and nothing further done at that time.

After recovery from that operation, the patient was discharged only to be readmitted five days later with another acute massive upper G.I. bleed. Because of the severity of the hemorrhage, he was taken directly to the operating room and reexplored. A vascular anomaly such as splenic or gastric artery aneurysm was suspected but could not be identified. The large ulcerated area was again oversewn and a distal gastrectomy carried out in the hope that this would control what was still interpreted to be arterial bleeding from the base of an ulcer. Exactly one week later, the patient again rebled and an angiogram revealed an aneurysm of the left gastric artery bleeding into the stomach. The left gastric artery and left hepatic artery arose from a common trunk. He was taken from the x-ray suite directly to the operating room, where his stomach was again reopened. Again the aneurysm could not be appreciated by inspection of palpation. Nevertheless, feeder arteries on the outer wall of the stomach were ligated and divided, and this largely controlled the bleeding. From within the stomach, the defect was enlarged

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and an aneurysmal sac lying entirely within the muscular wall of the stomach was removed. The defect in the stomach was repaired with interrupted black silk stitches from inside and the outer wall was inverted with silk. One year later, the patient continues to do well without evidence of further bleeding.

The aneurysm measured 1.5 × 1.1 centimeters in diameter and was a sacular non-atherosclerotic aneurysm.

Discussion

There have been multiple reports of patients having central and peripheral aneurysm of the mesenteric vessels. Best known and most reported are splenic artery aneurysms. All of these aneurysms are known for their propensity to rupture. This is a dreaded complication and frequently results in death. Most patients are in an older age group and cannot tolerate shock associated with rupture. The great majority are atherosclerotic aneurysms.

Aneurysms of the left gastric artery have been previously reported. Stachenfeld et al.[1] presented a case of aneurysm of the left gastric artery with preoperative angiographic diagnosis and elective repair.

Thomford et al.[2] reported aneurysms of the gastric arteries as a cause of intraperitoneal hemorrhage. Hypertension and atherosclerosis were common associated findings in 15 cases reviewed. A high mortality rate of 46 percent was reported.

In 1951, Prindle and Magladry[3] reported a case of aneurysm of the left gastric artery along with a review of the literature for the previous 20 years. They discovered one additional case. The patient they reported had vague abdominal pain and a filling defect on barium study of the stomach. Exploration and resection of the aneurysm led to relief of the symptoms.

Donaldson and Hamlin[4] reported three cases of massive hematemesis resulting from intragastric rupture of gastric artery aneurysms. Two of these patients died and all three aneurysms were arteriosclerotic. The two fatal cases involved aneurysms of the left gastroepiploic artery, and the third case was an aneurysm of the left gastric artery.

Michas et al.[5] recently reported a fourth case of hemoperitoneum caused by rupture of the gastroepiploic artery.

Acute sudden massive upper gastrointestinal hemorrhage may have many causes. Upper gastrointestinal series and gastroscopy are helpful in making the diagnosis in most instances. If a patient presents with acute massive gastrointestinal hemorrhage of unknown etiology, an arteriogram may be very helpful and should be done at an early stage.

The incidence of the entity is, of course, unknown. Many probably never cause symptoms and unless they are accidentally discovered remain undiagnosed throughout life.

Aneurysms of the gastric arteries must be kept in mind as a very infrequent cause of massive upper gastrointestinal hemorrhage. Early diagnosis and treatment probably represent the only chance for effective control of bleeding in those that rupture.

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Telephone Etiquette

Inter-Com buzzes: "Yes?"
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Hold . . . Hold . . . Hold . . . (minutes pass)
Dr. Ready: "Hello, Bruce!"

Sound familiar? Am I the only one that gets a cocklebur in my pants and does a slow-burn when I have to wait so long for a calling doctor to get to the telephone? Or a pharmacist?

Sometimes I could see another patient or two while I'm waiting. I feel that my time is just as valuable as the next fellow's time and that the patient's time is just as valuable as mine (emotionally if not monetary).

I am not guiltless in that I sometimes have my secretary place a call—but I make sure that I can be connected in seconds.

Sound picky? Maybe so, but think. Each delay throws off my schedule, delays my patients, my employees, my rounds, my wife, etc. In the future, I plan to make all calls to my colleagues myself and if he is busy will leave the message to call back. After all, I am calling at my convenience rather than his.

Maybe I shouldn't have written this—I may not get any more calls.—**Bruce C. Newsom, M.D., President, Muscogee County Medical Society.** *Reprinted with permission from the March 1978 Bulletin of the Muscogee County Medical Society.*

editorials
editorials
editorials

Physicians' Assistants

THERE SEEMS TO HAVE BEEN considerable misunderstanding in recent months, particularly by the lay press, of the position taken by the Medical Association of Georgia with regard to the training of physicians' assistants. Because of this, it seems appropriate to simply review the action taken by the House of Delegates at our recent meeting in Jekyll Island.

The Committee on Physicians' Assistants, chaired by William J. Rawls, in its report to the House of Delegates, noted that as of January 1978 there were 306 certified physicians' assistants within the state presumably employed. There were two P. A. schools actively involved in training programs; the Medical College of Georgia with 128 students and Emory with 80 students. It is anticipated that the Medical College will graduate 61 students this year while Emory will graduate 38. The projected enrollment in P. A. schools is anticipated to be 64 per year, with the M. C. G. accounting for 24 and Emory, 40. To finance this planned enrollment, the Medical College expects to spend $235,000 per year in training 24 students ($9,791.66 per student in state tax funds). Emory anticipates spending $200,000 per year to train 40 students ($5,000 per student in federal funds).

As the Committee learned more about PAs and their role, it became apparent that the present Georgia law lacked sufficient guidance governing PAs on the matter of their supervision. It also felt that this lack of clarity was generally shared by physicians practicing in the state. It was thought that an educational program might be designed to better inform physicians, PAs and in some instances patients of the proper functions and limitations of the PA.

With regard to the projected need for PAs in the future, no reliable information is currently available. In fact, it has not even been possible for a local health systems agency to project the need for physicians.

In the light of all these uncertainties and the considerable cost in tax monies involved in these training programs, the House of Delegates decision is:

1. The Medical Association of Georgia recommends to those currently involved with training and certifying physicians' assistants in the State of Georgia, that until the need for more physicians' assistants can be documented, the training and certification of physicians' assistants in Georgia be terminated and that current training programs be phased out as the current training cycles end.

2. That the Committee on Physicians' Assistants be continued for the purpose of (a) informing the MAG membership about the proper utilization of PAs according to the current Georgia law governing PAs. (b) Identifying areas of the PA law in need of clarification and making appropriate recommendations to the MAG Committee on Legislation for revising the law, and (c) Serving as a liaison between organized physician and PA groups.

It is hoped that this review of Association policy will shed some helpful light on this important issue.

Edgar Woody Jr., M.D.
Editor

The Physician: An Unknowing Pusher?

BECAUSE OF CONSISTENT EFFORTS of local, state and federal agencies, the amount of available heroin has been dramatically reduced in this country during the past year or so. The drug abuser, faced with a dwindling street supply, must therefore find other sources of narcotics, uppers, downers, sedatives, minor tranquilizers, etc. Increasingly, the physician is unwittingly becoming this new source.

The main goal is to "get high" and not simply to avoid narcotic withdrawal symptoms; therefore, the addict will go to almost any length to achieve this high. Not only will he feign illness, whine, cry, prostitute, or lie (by saying his doctor is out of town), he may also resort to threats, alter legitimate prescriptions or, more common now, actual forgery after stealing prescription pads.

If you take call for other physicians, you may get requests from addicts asking you to call in a prescription which your colleague supposedly has given him. It is also common for the addict to call the doctor's nurse and have her call in a prescription, at times, without the physician's knowledge.

Any patient who comes to you requesting narcotics and drugs of abuse should be thoroughly identified by date of birth, social security number, street address, etc., and his condition completely evaluated through appropriate testing and history before such drugs are given. If you can prove you are given false information, then this may be considered fraud by deception and prosecution can ensue.

It might be worthwhile to know your local, state narcotics inspector and have his number available so that you can contact him if you have a suspicious patient. They frequently have a list of addicts who float from doctor to doctor.

Legitimate addicts who are seeking treatment should be referred to your local drug abuse center. According to the Federal Drug Enforcement Administration regulations, physicians cannot treat addicts for their addiction with narcotics unless they register with the Administration and stringently comply with the security and record-keeping requirements.

A better system of controlling prescriptions on the drugs of abuse is mandatory. The triplicate system is used in many states and has just about eliminated the forgery problem. With this system, the first prescription is given to the patient, the second is placed in the patient's file and the third goes to some agency in the state. The three prescriptions have the same number so that it is extremely easy to crosscheck.

The addict will not hesitate to get a physician in trouble or to attempt blackmail once he has obtained narcotics from him. It is, therefore, vitally necessary for the physician to protect himself so that he will not become the "unknown pusher."

M. B. Sell, M.D.
Associate Professor of Psychiatry
Medical College of Georgia
Medical Director, Greenbranch
Drug & Alcohol Clinic
Augusta, Georgia

president's letter



Who Speaks for Practicing Physicians?

MANY ARTICLES ARE APPEARING in the press dealing with the problem of high doctor fees. They range from editorials, to reviews by syndicated columnists, to letters to the editors by "concerned citizens." The American Medical Association has received the brunt of criticism by reporters and concerned citizens alike.

Surprisingly, the average individual, who himself belongs to a pressure group, such as the Teamsters or auto workers unions (more out of compulsion than choice), considers the AMA to be an extremely powerful union of doctors. He is convinced that each practicing physician, as a requirement of his practice for licensure, *must* belong to the AMA. He is totally unaware that barely 40 percent of our ranks belong, and that we indeed belong out of choice rather than compulsion. If told, he would never believe that 25 percent of the physicians practicing in Georgia do not even belong to the Medical Association of Georgia.

Without doubt, the American Medical Association's Political Action Committee (AMPAC) is a potent force in the political arena, working for the good of the patient and the doctor alike. I am amazed at its effectiveness, when one considers that it is the only potent united force representing our profession in spite of the fact that only 40 percent support it. I am convinced that if there were no AMA, some sort of total care government (federal) program would now long since have been a reality. Without total physician support, however, I think we are only delaying the inevitable. We win a few isolated battles, but the outcome of the war seems little changed from ultimate defeat of our forces.

How would the situation be if we (all 400,000+ strong) all supported our AMA? Suppose we had the solid unity of the Teamsters, or the United Auto Workers. Would our profession be better off? I think it probably would.

I would never wish mandatory as opposed to voluntary membership. We are one of the last bastions of professionalism. Certainly the school teachers, nurses, and other like professional groups have lost, to a significant degree, their professionalism by compulsory unionism.

The time is growing late. With every passing day, federal (and state as well) government intervention in the private practice of medicine becomes a more firmly entrenched reality.

Excuses abound by our colleagues, that the AMA is a stone-age relic, and they either have cancelled their membership or have never joined because of this policy or that with which they do not agree. These dissidents, who themselves represent an overwhelming majority, sit back and criticize the AMA, but I have yet to see them propose a viable alternative.

We all know the maxim "In unity there is strength." Conversely, in disunity there is weakness and vunerability.

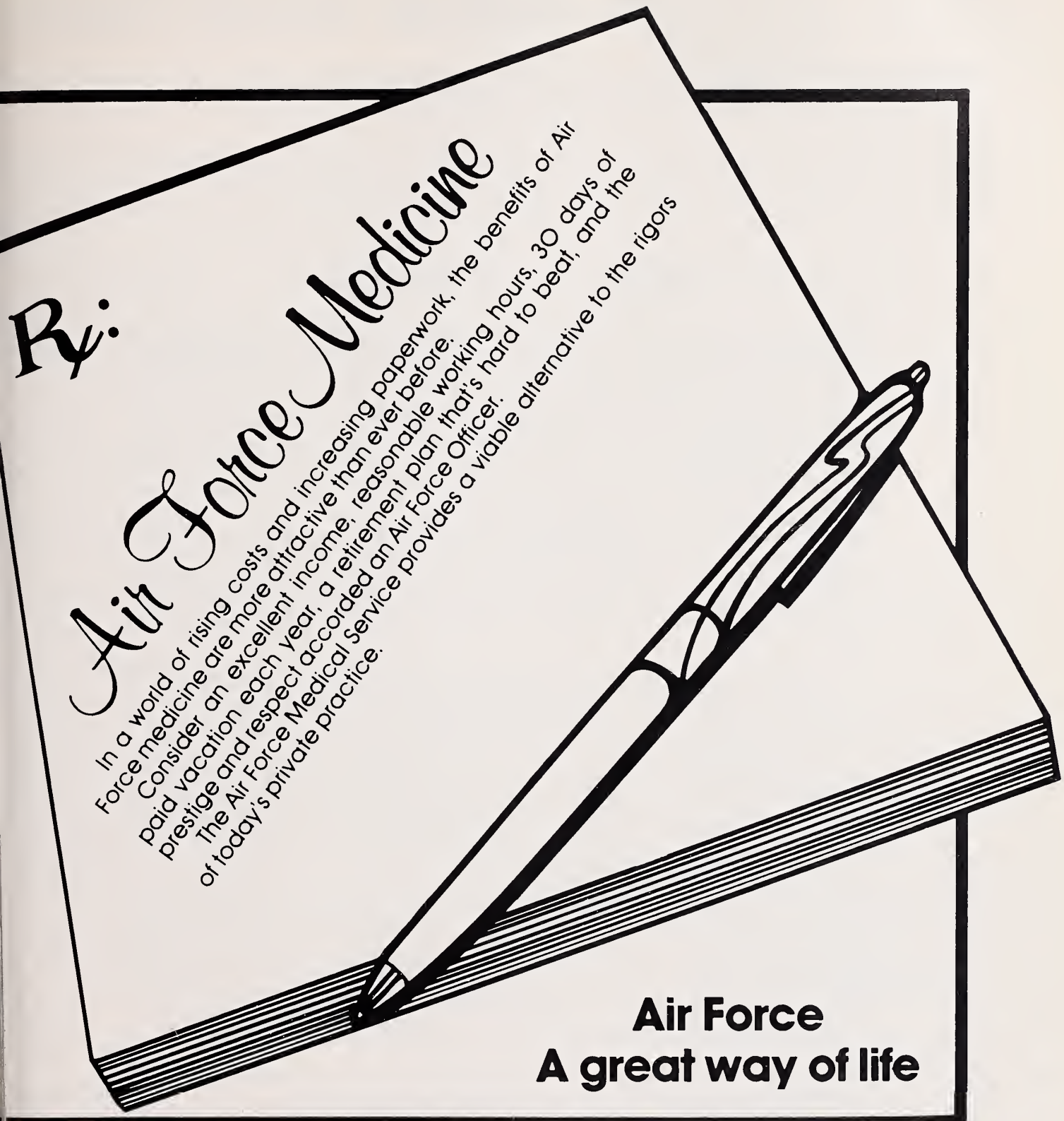
Financially, the practicing physician, in general, represents one of the most affluent segments of our economy. Professionally, he still enjoys a significant degree of freedom (albeit this is daily being constricted). His "tunnel vision," however, does not permit him to see that we must have one single, powerful organization like the AMA that speaks for us in the national arena that is rapidly becoming inundated by a morass of powerful pressure groups.

Who indeed, speaks with a powerful voice for the independent, practicing physician?

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG



FOR MORE INFORMATION CONTACT:
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Suite 208, 3050 Presidential Dr.
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I've told this before . . .

(Editor's Note: Never underestimate the powers of a $6.00 rooster! You'll see why in this story by Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories to the Journal, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Whitey — a Sexy Rooster

EDD SCRUGGS — AN EMINENT FALCONER — is quite an authority on hawks, birds and chickens and, while Edd is an honorable and honest businessman, some of his closest friends have mildly suggested that, at times, he might stretch the truth when discussing some of his winged enamoradoes.

Some few years ago, said Edd, a farmer friend of his had a dozen hens that laid eggs as well as expected, but the eggs wouldn't hatch. He had changed their feed, put some kind of medicine in their drinking water — all to no avail. Finally some chicken man told the farmer that the problem was his old rooster; for some reason, although he could function, he was not fertilizing the eggs — most likely due to his age.

And that's why Ole Man Ezra Brooks came home one Saturday morning with a young white Leghorn rooster in a feed sack. He put him in a chicken coop and gave him some corn.

His wife, Lula Belle, came out and looked over the rooster rather critically. She asked Ezra how much he paid for him and when he answered "$6.00," she hit the ceiling.

"Six dollars?" she almost screamed. "Just think how hard we have to work to make one dollar!"

Ezra tried to calm her by saying that the rooster was guaranteed for six months and if for any reason they were not satisfied with him, they could get their money back.

When the young rooster was liberated from the coop, the first thing he did was to look over his future domain. He liked what he saw with the exception of a big old Dominique rooster, who stood proudly there by the fence, surveying his harem. Not being one to defer something that had to be done, the white rooster made a beeline to the old cock; he didn't mess around with ruffled feathers, circling and squawking, etc. He just knocked the living daylights out of him and before the old rooster could get up off the ground, the youngster had whipped him so soundly with beak, spurs and wings that when he did manage to get up, he ran as hard as he could and went under the barn.

Whitey crowed a couple of times, dropped one wing and strutted about and talked rooster talk to his newly acquired lady companions; none paid much attention to him; they just kept on scratching, pecking a blade of grass or an insect. Then he proceeded with enthusiasm to perform the duties that were expected of him. He had troubles with some of the young pullets who really gave him a merry chase. This worried Lula Belle, who finally said to Ezra, "That sex-crazed rooster is going to run himself to death as hot as it is today." It didn't worry Ezra too much until he heard the guineas carrying on and then he saw the old drake duck with several of his wives, airborne, quacking in alarm and heading toward the lake.

In a little while, Lula Belle called Ezra and said "Your fine rooster is laying down yonder in the field and looks like he is dead; the buzzards are already circling over him."

Sure enough, he could see Whitey flat on his back with wings partially outstretched and a lone buzzard circling over him, lower and lower. Mr. Brooks cautiously walked down and stood under a pecan tree nearby the rooster; he noted a little quick movement in one of his legs and his spur pointed over head, and Mr. Brooks understood him to say "Sh, Sh, be quiet, be still. I've got her coming down. . . ."

J. G. McDaniel, M.D.
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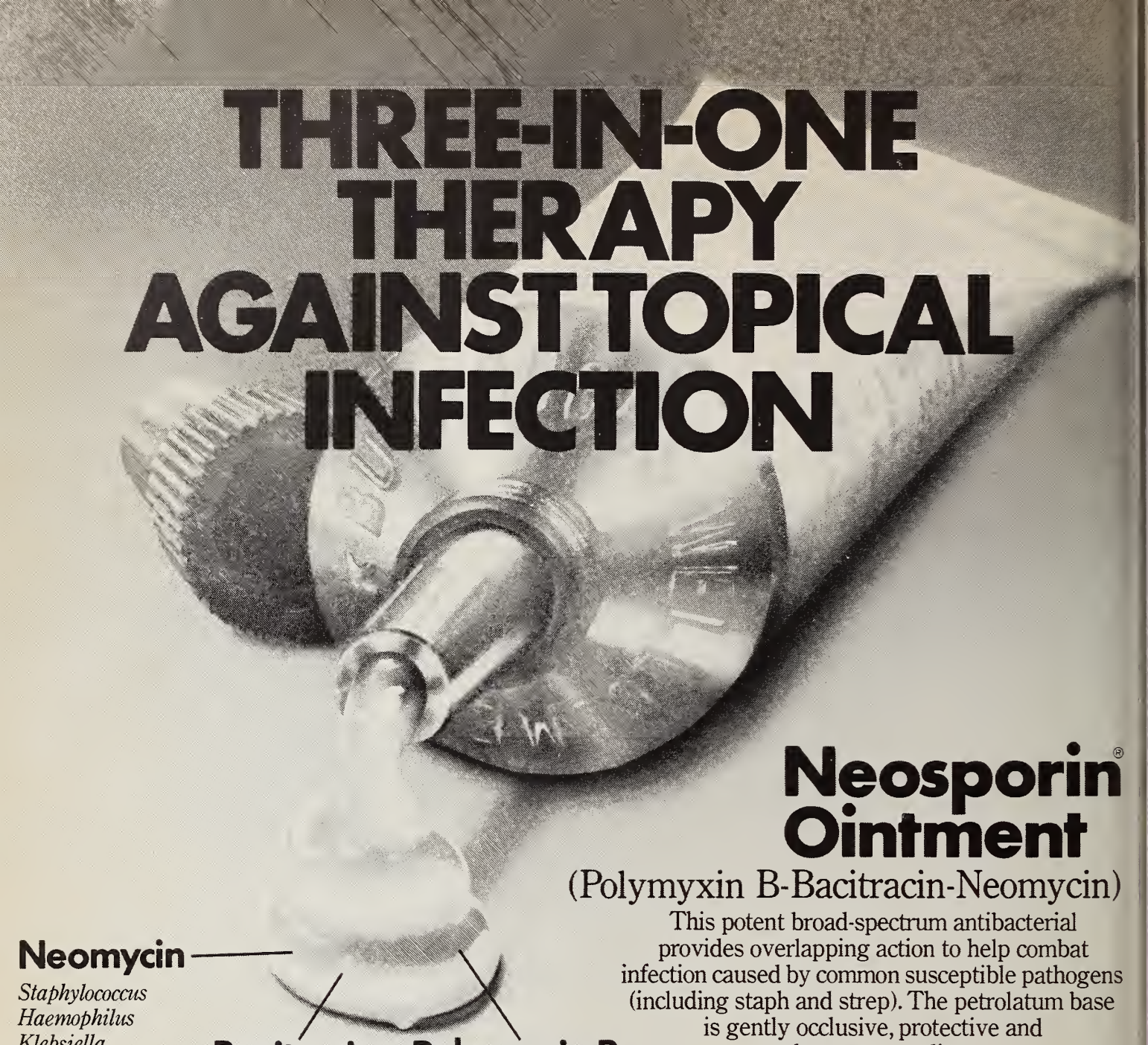
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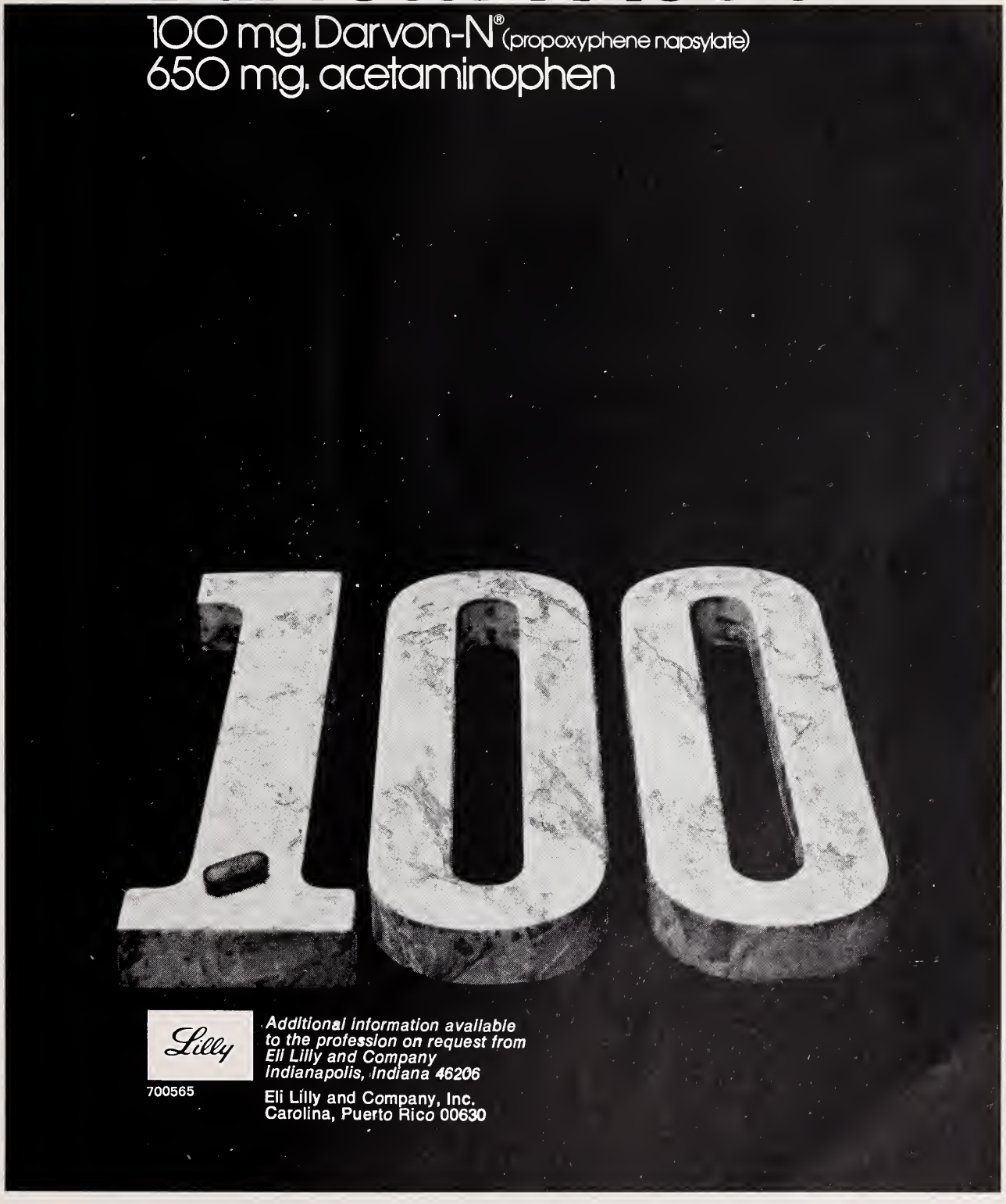
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Arterial Ischemia of the Lower Extremities Part I

PHILIP L. BREWER, M.D., *Columbus**

ARTERIAL INSUFFICIENCY of the lower extremities offers a wide spectrum of clinical presentations, extending from minor discomfort on walking long distances to septic gangrene producing a life-threatening systemic illness. The variability of the complaints, which is accounted for by differences in both the anatomic distribution and the severity of the arterial occlusive process, challenges the clinician, perhaps less in his diagnostic ability than in his selection of the appropriate therapy for the individual patient. In the majority of patients, the etiology of the occlusive process is arteriosclerosis. Less commonly, arterial emboli or injuries with failure to reconstitute flow produce the ischemia. Our discussion will concentrate on the lesions produced by arteriosclerosis.

As indicated above, the anatomic distribution is important. DeBakey[1] has pointed out on many occasions that the term generalized arteriosclerosis is misleading. Although it is true that the disease process may involve many organ systems, the lesions themselves are usually segmental, with "skip areas" of relatively normal artery interspersed between the obstructive lesions. This characteristic is, of course, the basis on which surgical treatment using bypass grafting or endarterectomy is based. In occlusive disease of the arteries of the lower extremities, there is a predilection for atheromatous plaques to develop in the common iliac arteries, in the superficial femoral arteries at the adductor canals, and in the proximal small arteries of the leg, just beyond the branching of the popliteal artery. Somewhat less common sites of obstruction are in the terminal aorta, and at the origin of the deep femoral artery in the proximal thigh. Sudden occlusions in the distal popliteal artery are most often embolic in nature, and embolus should be strongly suspected in the appropriate clinical setting such as recent myocardial infarction, atrial fibrillation, or mitral stenosis. Although occlusions of the smaller tibial or peroneal arteries are more common in diabetic patients, they are by no means confined to that group.

Intermittent claudication is widely recognized as the earliest and most characteristic symptom of mild or moderate arterial ischemia of the lower extremity. This symptom typically consists of an aching discomfort which develops in the affected muscle group, brought on by exercise and relieved within a few minutes by rest. It is important to realize that not all patients complain of actual pain; some describe a "giving out" of the extremity or the development of a heavy leaden feeling. The area in which the discomfort occurs correlates with the anatomic distribution of the

* Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

Dr. Brewer's address is Medical Arts Building, Room 201, Columbus, Ga. 31901.

occlusive process. For example, occlusion of the distal aorta produces claudication of the buttocks. A unilateral occlusion in the iliac system may produce claudication of the entire leg, although usually the calf discomfort is more severe; whereas obstructions in the superficial femoral artery produce claudication of the calf only. Varying degrees of impotency in the form of inability to sustain an erection are common with occlusive disease at the aortoiliac level.

More advanced degrees of arterial insufficiency produce pain in the extremity which continues even at rest. This pain usually does not occur in the muscles of the thigh or calf, but is perceived as a severe unremitting pain in the foot, ankle or toes, occasionally described as being of a burning character. Partial relief is afforded by allowing the extremity to hang in a dependent position, so that often the patient will spend his evenings sitting on the side of the bed, or in a chair, to obtain relief. This eventually results in swelling of the extremity, so that confusion with thrombophlebitis may exist. The dire implications of rest pain have been pointed out by Linton,[2] who has stated that once this symptom appears, tissue necrosis will invariably occur within a year and often much sooner. Tissue necrosis, the final stage of severe arterial impairment, may take the form of an ischemic ulcer, which occurs on the foot or ankle, or gangrene, which usually begins in one or more toes.

The physical appearance of the ischemic lower extremity is well known and its description need not be belabored. Rubor on dependency, pallor on elevation, and coolness are frequent findings. The degree of impairment of the circulation may be estimated by elevating the foot, emptying it of blood, and then placing the extremity in a dependent position noting the time required for rubor to develop. With chronic ischemia, the foot and lower leg are hairless, with a shiny atrophic appearance of the skin, although this appearance need not be present, even in advanced ischemia, if the process has developed rapidly. Some abnormality of the pulses in the femoral, popliteal, posterior tibial or dorsalis pedis arteries is usually noted, although again, this may vary with the severity and anatomic distribution of the occlusions and with the extent of collateral circulation. An absent or diminished femoral pulse, often accompanied by a bruit, is a sign of arterial narrowing at the aortic or iliac level. When a femoral pulse is strong, but no pulses can be felt below that level, an obstruction of the superficial femoral artery in the common site at Hunter's canal can be suspected. Absence of foot pulses with maintenance of a femoral and popliteal pulse is the usual finding in patients with small artery disease, often of the diabetic type, although an embolus to the distal popliteal artery can produce similar alterations. The development of collateral circulation can produce interesting and sometimes surprising pulse abnormalities. For example, a patient with a long-standing iliac occlusion may have no perceptible femoral pulse; however a faint popliteal pulsation may be present, and sometimes excellent pedal pulses may be detected. Pulsations in such situations are often inconstant and may be easily felt at certain times but absent at others. An oscillometric determination using a sphygmomanometer can be useful, if one is unsure about the presence of pulsations.

Angiography, the only precise way to accurately delineate the extent and severity of the arteriosclerotic process, must be considered once the clinical diagnosis is established. This is not to say that every patient with suspected arteriosclerosis of the lower extremities needs angiographic evaluation. Certainly patients with mild symptoms who are not being considered for surgical therapy may be followed without the benefit of exact knowledge of their anatomic abnormalities. In general, patients in whom surgical therapy might offer benefit and patients with obscure pain syndromes in whom arterial insufficiency is being considered as a causative or contributing factor should receive angiography. The well known safety of angiography of the lower extremities, which is without even the rare but catastrophic complications associated with cerebral or coronary angiography, tends to make the use of this extremely valuable diagnostic tool more liberal.

To avoid errors of interpretation, radiographic studies must be of high diagnostic quality. Many advances have been made since Dos Santos of Lisbon first introduced the technic of of translumbar aortography in 1923. This method of direct

percutaneous puncture of the aorta is used less frequently now, and the Seldinger technic of retrograde positioning of a catheter over a guide wire introduced through the femoral artery has gained in favor. The latter technic requires a pressure injector for instillation of radiopaque material into the terminal aorta and subsequent evaluation of the distal circulation with timed exposures as the dye flows down the extremities. Complications are unusual but include bleeding or thrombosis at the site of the femoral artery puncture and, rarely, allergic reactions to contrast material. Despite the popularity of the retrograde approach, translumbar aortography remains a useful and extremely safe method of evaluation for patients in whom femoral pulses are absent or in whom difficulties are encountered in advancing the guide wire upwards into the aorta. If information concerning only one extremity is desired, and if there is no reason to suspect obstruction at the aortic or iliac level, simple direct puncture of the femoral artery and injection of the dye at this point is sufficient.

The development of surgical technics for bypass grafting to the tibial or peroneal arteries has made satisfactory visualization of these small distal vessels mandatory. Proper attention to details of injection, timing, and resolution are necessary for satisfactory films, and the use of rapid cassette changers is extremely valuable. All of the above procedures may be performed under local anesthesia with adequate premedication and patient rapport. If lidocaine is added to the contrast material, pain associated with dye flowing through the ischemic limb can be eliminated.

Once the diagnosis of arteriosclerosis sufficiently advanced to produce symptoms or physiological alterations such as bruits or abnormalities of the pulse is established, some therapeutic measures would seem to be indicated. These efforts may vary from the simplest measures to alter risk factors in minimally symptomatic patients to aggressive surgical procedures in patients threatened with loss of limb. Recent reports of the effect of low fat diets and cholesterol lowering drugs on the course of arteriosclerotic disease have proved disappointing, however, some diet modification in younger patients would seem prudent. Daily exercise in the form of walking is excellent advice for these patients and will improve muscle tone and perhaps increase the development of collateral circulation. Cigarette smoking interferes with lung function, is detrimental to oxygen transport and produces vasospasm, thereby aggravating the symptoms of tissue hypoxia at many levels. Abstinence from cigarette smoking should be urged for all patients with clinically evident arteriosclerotic disease. Vasodilators may be prescribed but are probably of little value except in the rare patient with a disorder of the small arteries, vasospasm, and a demonstrably slow circulation.

For more severely symptomatic patients, surgical treatment may be indicated. The operative procedures to improve circulation to the lower extremities can be arbitrarily divided into two groups; those performed on obstructions located within the abdomen, that is, aortoiliac occlusive disease, and those performed on the extremity itself for obstructive processes in the femoral, popliteal, tibial, or peroneal arteries.

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(Continued next month in the September 1978 issue)

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DOES THE PUBLIC HAVE the right to demand the disclosure of information and records in the possession of Professional Standards Review Organizations (''PSROs'')? Indeed it does in some instances, according to the United States District Court for the District of Columbia, which, in a recent opinion, raised serious doubts as to the future effectiveness of the peer review mechanism which Congress chose to establish through the enactment of the PSRO legislation.

The PSRO Legislation

Subject to the establishment of the Medicare and Medicaid programs, Congress recognized the need to curb the delivery of unnecessary or needlessly expensive medical care in order to contain the cost of government-funded medical services. Moreover, since a substantial portion of health care funds were expended for inpatient hospital care, Congress recognized the necessity of implementing a program to assure that the provision of institutional health care services was both necessary and of adequate quality. Consequently, after an unsuccessful attempt to alleviate these problems through an ''in-house'' system of review,[1] Congress, through the enactment of the PSRO legislation, created a comprehensive system of external monitoring of hospital-based delivery of health care services.[2]

The thrust of the PSRO legislation was the development of qualified organizations in federally-designated areas throughout the country (''PSRO areas'') whose basic function was to determine the necessity and adequacy of the services rendered by the Medicare and Medicaid practitioners and providers in their areas; more specifically, this determination entailed the review by a PSRO, on a routine basis, of: (1) the medical necessity of each hospital admission; (2) the medical necessity of continued hospitalization, and (3) the systematic reassessment of the review methods utilized by the PSRO (''medical care evaluation studies'' and ''profile analyses'').[3]

Disclosure Under the Freedom of Information Act

Pursuant to the Freedom of Information Act (the ''Disclosure Act''),[4] federal agencies and ''quasi-agencies'' are required to make certain information available to the public, unless that information is specifically exempted from disclosure by the act itself.[5] Thus, the threshold inquiry in determining the applicability of the Disclosure Act is whether or not the organization from which disclosure is sought may be categorized as an ''agency.''

The Disclosure Act itself offers merely a general definition of the term ''agency'': an ''agency'' means ''each authority of the government of the United States, whether or not it is within or subject to review by another agency.''[6] Consequently, since the Disclosure Act does not create a precise standard as to whether any one organizational entity is or is not an ''agency,'' it has been up to the courts to make this determination. Thus far, the courts have used a functional,

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

case-by-case analysis of numerous factors[7] which indicate whether or not an organization has what is referred to as the "requisite indicia of agency status."[8]

Application of the Act to PSROs

In the recent case of *Public Citizen Health Research Group v. Department of Health, Education and Welfare,*[9] a court was for the first time faced with the question of whether or not a PSRO is an "agency" within the terms of the Disclosure Act. In that case, a nonprofit research organization, engaged in consumer advocacy in connection with certain health and safety matters affecting Medicare and Medicaid patients, sought certain information and documents from the National Capital Medical Foundation, Inc., the organization designated by the Secretary of HEW as the PSRO for the District of Columbia.

The Court first analyzed the "indicia of agency status" factors and determined that the PSRO was in fact an "agency" within the meaning of the Disclosure Act. In that context, the Court found to be significant the facts that the PSRO was financed by the United States, was a creature of federal statute, performed executive functions and "operate(d) under direct, pervasive, continuous regulatory control affecting even minutia of [its] procedures and functions."[10] Also significant to the Court's holding was the fact that, with certain limited exceptions, the PSRO's determinations as to the medical necessity and adequacy of the services provided were, unlike organizations acting as consultants, final and binding on the Department of HEW.[11]

Once it was determined that the PSRO was an "agency" and thus subject to the Disclosure Act, the Court was next faced with the problem of balancing the disclosure requirements of the Disclosure Act against the confidentiality provisions of the PSRO legislation which specifically prohibit the disclosure of any data or information acquired by a PSRO in the exercise of its duties and functions.[12] In spite of this specific prohibition in the PSRO legislation against disclosure, the Court concluded that the confidentiality provisions of the PSRO legislation must give way to the disclosure provisions of the Disclosure Act; significantly affecting this decision were the facts that the Secretary of HEW retained some discretionary authority over the release of PSRO data in certain instances[13] and that the PSRO legislation, enacted subsequent to the Disclosure Act, did not "flatly exempt" the PSROs from the Disclosure Act's requirements.

It is important to note that the Court did not hold that any of the PSRO data or information sought by the plaintiff in *Public Citizen* must be disclosed; rather, the Court held that a PSRO is an "agency" for purposes of the Disclosure Act. Thus, the Court remanded the case for determination by the PSRO of whether or not the "medical" or other exemptions of the Disclosure Act were applicable so as to preclude the disclosure of any or all of the PSRO data or information sought by the plaintiff.

The Potential Effect of the Public Citizen Decision

The most obvious result of the *Public Citizen* decision is that the information and data procured by PSROs in the exercise of their review functions will become generally available to the public through the Disclosure Act, unless specifically excluded pursuant to the exemptions set out in footnote 5, *supra*. In this regard, it remains to be seen how broadly the "medical" exemption will be construed. Any general availability of PSRO information and data will surely hamper the effectiveness of the PSRO review mechanism. As the Court in *Public Citizen* itself recognized:

> "[We] are well aware that the affidavits and attitudes of the medical profession strongly suggest that the peer review mechanism which Congress wisely established in enacting the PSRO program will experience a severe setback, if not fatal blow, should PSRO records become generally available through the [Act]. But the remedy for alleviating these justifiable concerns lies with Congress, not the Courts."

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Until such time as Congress does act to specifically exempt PSROs from the provisions of the Disclosure Act, however, the public does appear to have the right to demand the disclosure of PSRO information and records not otherwise exempted by the terms of the Disclosure Act itself.

Notes

1. 42 U.S.C. §§1395y(a)(1) and 1396a(30) required each hospital to form physician committees to oversee and control the utilization of services provided to Medicare and Medicaid patients within their institution.
2. 42 U.S.C. §1320c-1 *et seq.*
3. HEW, *PSRO Program Manual,* §705, at VII-5 to VII-16 (1974).
4. 5 U.S.C. §552.
5. The Act sets out nine specific types of information which are expressly exempted from the disclosure requirements; these include matters of national security, internal personnel rules, trade secrets, personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of privacy, investigatory records compiled for law enforcement purposes, and geological and geophysical information. 5 U.S.C. §552(b)(1)-(9).
6. 5 U.S.C. §552(e), which refers to the definition of "agency" as specified in the Administrative Procedure Act, 5 U.S.C. §551.
7. See, e.g., *Ciba-Geigy Corp. v. Mathews,* 428 F. Supp. 523 (S.D.N.Y. 1977); *Rocap v. Indiek,* 539 F.2d 174 (D.C. Cir. 1976); *Washington Research Proj., Inc. v. Department of HEW,* 504 F.2d 238 (D.C. Cir. 1974); *Soucie v. David,* 448 F.2d 1067 (D.C. Cir. 1970).
8. *Ciba-Geigy Corp. v. Mathews, supra* at 527.
9. U.S. District Court, District of Columbia, Civ. No. 77-2093 (April 25, 1978).
10. C.f. *Ciba-Geigy Corp. v. Mathews, supra* at 528.
11. See *Washington Research Proj., Inc. v. Department of HEW, supra* at 248 ("The important consideration is whether it has any authority in law to make decisions. Only if the agency automatically adopts the organization's decision as its own can it be considered the functional equivalent of an agency.").
12. 42 U.S.C. §1320c-15.
13. The Secretary of HEW is authorized under 42 U.S.C. §1320c-15 to provide by regulations for the disclosure of information in order to "assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care."

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One free copy of the 1978 Roster was mailed to each active member of the Medical Association with the August 1978 issue of the **Journal.**

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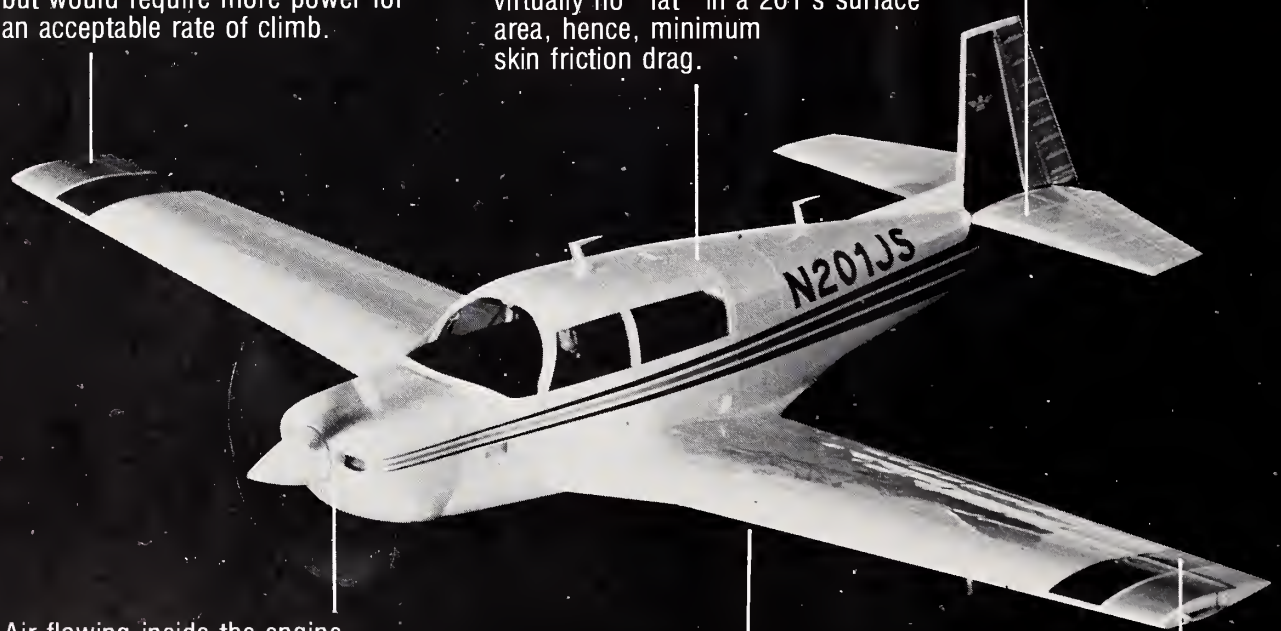
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SOCIETIES

The May meeting of the **DeKalb Medical Society** featured a simulated malpractice trial. Doctors and lawyers played roles in the "play" presented by the Decatur-DeKalb Bar Association. The jury found the defendant guilty.

PERSONALS

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Statesboro physician **H. Randolph Smith, M.D.,** has been named a diplomate of the American Board of Family Practice.

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Third District

A. G. Hendrick, M.D., was presented with the Liberty Bell Award by the Houston County Bar Association. The award is given annually to a Houston County citizen not directly connected with the law who, "through his life and work, has rendered outstanding service to his community, has encouraged greater respect for the law and the courts, and has stimulated a deeper sense of individual responsibility to the end that citizens recognize their duties as well as their rights."

A graduate of Emory University School of Medicine, Dr. Hendrick has practiced medicine in Perry for almost 40 years. He was honored in part for giving free treatment to inmates of local jails.

Fourth District

Robert M. Fine, M.D., is the 1978-79 president of the Southeastern Dermatological Society.

The Decatur-DeKalb Bar Association gave **O. Wytch Stubbs, M.D.,** its 1978 Liberty Bell Award "for outstanding community service." Dr. Stubbs was honored in part for his five years' service as volunteer medical director of the Scottdale Medical Clinic.

Fifth District

Edwin C. Evans, M.D., has been elected for a five-year term to the Institute of Medicine of the National Academy of Sciences.

William E. Silver, M.D., recently presented a paper, "Pre-Operative Facial Analysis: Wax Moulage—A New Look at an Old Method," at the Scientific Meeting of the American Academy of Facial Plastic and Reconstructive Surgery.

Sixth District

Wrightsville physician **William A. Dodd, M.D.,** has been elected president of the newly organized American Health Care Medical Association. The organization was founded "seeking to improve health care in long-term facilities."

Thomaston physicians **Ralph Warnock, M.D.,** and **Wayne Dodgen, M.D.,** have been named diplomates of the American Board of Family Practice.

Eighth District

R. A. Pumpelly, M.D., Jesup, has completed requirements to retain active membership in the American Academy of Family Physicians.

Ninth District

Cherokee physicians **David E. Field, M.D.,** and **Homer Lecil Gold Jr., M.D.,** have been named diplomates of the American Board of Family Practice.

Members of the Lanier Park Hospital Medical Staff (Gainesville) placed seventh in the Third Annual Hospital Corporation of America's Physicians Relay held recently in Nashville, Tennessee. Sixty-eight teams from across the country entered the competition. Each participant ran two miles and the teams' scores were computed by totalling the individual times. The Lanier Park team: **Joe Johnston, M.D.; Lee Martin, M.D.; James Parks, M.D.,** and **Frank Shorter, M.D.**

Tenth District

Ben C. Barrow, M.D., who practiced medicine in

Monticello for 18 years and then moved to his home town of Athens, has been named "Doctor of the Year" in Athens.

Hartwell physicial **Louis G. Cacchioli, M.D.,** has retained active membership in the American Academy of Family Physicians.

John R. Curtis, M.D., director of the University of Georgia Health Services, has been elected president of the American College Health Association.

J. Graham Smith Jr., M.D., professor of dermatology and head of the Department of Dermatology at the Medical College of Georgia, Augusta, has been named president-elect of the Society for Investigative Dermatology.

DEATHS

Thomas Martin Adams

Thomas Martin Adams, M.D., of Montezuma, died May 24 at the age of 74. A native of Elberton, he had practiced medicine in Macon County for 49 years before his retirement in January of last year.

Dr. Adams maintained the Macon County Clinic for several years and was once mayor of Montezuma. For many years, he was Macon County High School's athletic physician and the school's stadium was named The Tom Adams Stadium in his honor.

He was a graduate of the University of Georgia and the Medical College of Georgia.

Survivors include: his mother, Mrs. L. B. Adams, Hawkinsville; four sisters; three brothers.

Elton Smith Osborne

Elton Smith Osborne, M.D., Savannah, died May 9. He was 101 years old.

Dr. Osborne, a native of Savannah, had practiced medicine there until his retirement at the age of 98.

He was graduated from the University of Maryland Medical School, took his internship at the Mercy Hospital in Baltimore and took his residency at Philadelphia General Hospital.

Survivors include: two daughters; three sons (all of whom are doctors); 19 grandchildren; nine great grandchildren.

Jacob Lieucester Shirley Sr.

Jacob Lieucester Shirley Sr., M.D., died May 26 at the age of 99 (he would have been 100 years old in December).

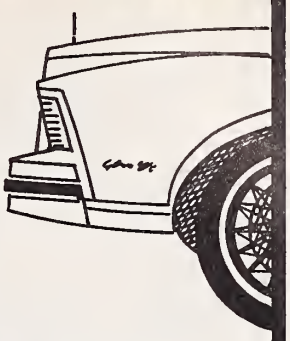
Dr. Shirley was born in the British West Indies, came to the U.S. in the early 1900s, and received his medical degree from Meharry Medical College in Nashville, Tennessee. Looking for a small town in which to settle and begin his practice, he visited Dawson, met his future wife, and practiced there for 68 years—until he officially retired this year.

It is said that in 1918, during a major flu epidemic, he treated some 1,600 cases, all but three successfully.

During his lifetime he received many honors and was active in civic organizations and professional societies. In 1960, he was awarded the Fifty Years' Distinguished Service Plaque by his alma mater.

Survivors include: six children, one of which is Jacob Lieucester Shirley Jr., M.D., Albany; two sisters; four grandchildren.

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Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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Dosage: Not recommended for infants less than two months of age.

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Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

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lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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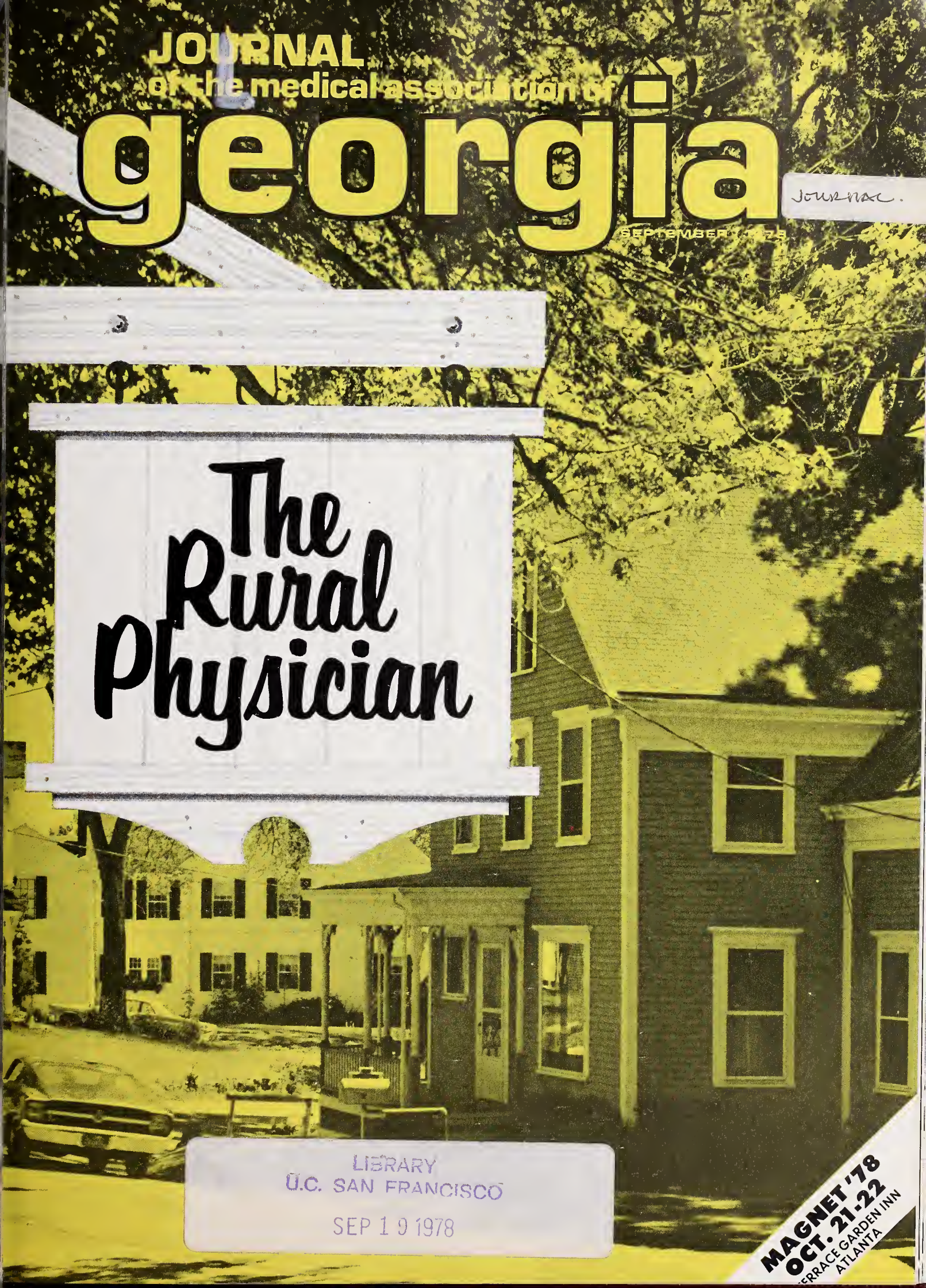
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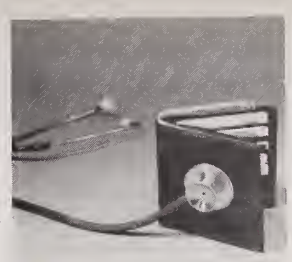
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COVER

The rural physician is important in Georgia. MAG is working, through its Access to Health Care Committee, to help put doctors and communities together. Chairman of that Committee, M. Julian Duttera, M.D., tells you about the Second Physician Recruitment and Pre-Practice Seminar, page 727. On page 708, find out how one group of Georgia physicians worked out an unusual solution to one community's medical care availability problems. Cover design by Bob Hamill.

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_____ $____each $_____

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($20.00 Admin. fee charged on Postgraduate Course Refunds).
Dinner Dance and Luncheons—9:00 a.m. day of the event.

Tickets must be picked up in the SMA registration area—Friday, November 10, 12:00 noon-5:00 p.m., Peachtree Plaza Hotel; Saturday-Monday, November 11-13, 8:00 a.m.-5:00 p.m.; Tuesday, November 14, 8:00 a.m.-12:00 noon, Georgia World Congress Center.

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NOVEMBER 11-14, 1978

ATLANTA, GEORGIA

SATURDAY		SUNDAY		MONDAY		TUESDAY
AM	PM	AM	PM	AM	PM	AM
Dermatology	Dermatology	Dermatology—Clinical Session (Emory University)	Urology	Anesthesiology	Colon & Rectal Surgery	George Papanicolaou Memorial Seminar (Gyn., Ob., Path., & Rad.)
Gynecologic Oncology (Gynecology—Postgrad. course)	Gynecologic Oncology (Gynecology—Postgrad course)			Otolaryngology	Allergy	
American Fertility Society (Postgrad. course) (Atlanta Hilton)	American Fertility Society (Postgrad. course) (Atlanta Hilton)	Anesthesiology	Dermatology Mini-courses (3): Acne, Warts, Aging Skin	Zola Cooper Clinicopathologic Seminar (Derm. & Path.)	Otolaryngology	Otolaryngology
		Neurology, Neurosurgery, & Psychiatry				
Liver Disease (Gastroenterology—Postgrad. course)	Liver Disease (Gastroenterology—Postgrad. course)	Gastroenterology	*Gastroenterology, Emergency Medicine, Radiology, & Surgery	Medicine & Georgia Society of Internal Medicine	Pediatrics	Allergy
Pathology	Evaluation of Blood Transfusion Complications (Pathology-Postgrad. course)	Family Practice	Orthopedic Surgery	Plastic Surgery	Plastic Surgery	Radiology & RSNA
Cardiology (Medicine—Postgrad. course)	Cardiology (Medicine—Postgrad. course)	Urology				
Care of the Multiple Injured Patient (Orthopedic Surgery—Postgrad. course)	Care of the Multiple Injured Patient (Orthopedic Surgery—Postgrad. course)	Orthopedic Surgery	Ophthalmology	Orthopedic Surgery	Orthopedic Surgery—Clinical Session	
		Maxillofacial Surgery (Plastic Surgery—Postgrad. course)				
Georgia Neurosurgical Society	Georgia Neurosurgical Society	Ophthalmology	Medical Otolaryngology: Current Concepts in the Treatment of Common Disorders (Otolaryngology—Postgrad. course)	Ophthalmology	Pediatric Dermatology (Postgrad. course)	
Cardiopulmonary Resuscitation (Postgrad. course)	Cardiopulmonary Resuscitation (Postgrad. course)	Emergency Medicine				
Radiology	Radiology	Radiology	Gynecology	Pediatrics	Radiology & RSNA	
Ophthalmology	Surgery	Surgery	Psychiatry	Neurology, Neurosurgery, & Psychiatry		
Hand Surgery (Plastic Surgery—Postgrad. course)	Hand Surgery (Plastic Surgery—Postgrad. course)	Chest Diseases	Society for Investigative Dermatology	Emergency Medicine	Obstetrics	
	Ophthalmology				Pathology	
*Neurology & Medicine	Head & Neck Surgery (Otolaryngology—Postgrad. course)	Atlanta Society of Pathologists	Atlanta Society of Pathologists	Surgery	Surgery	
				Urology (Postgrad. course)	Urology (Postgrad. course)	
Family Practice	*Medicine & Georgia Thoracic Society	Southern Gynecological & Obstetrical Society	Chest Diseases	Dermatology for the Non-Dermatologist (Postgrad. course)	Dermatology for the Non-Dermatologist (Postgrad. course)	
Chest Diseases	Neurology					

*Joint session indicated with Section in charge of program listed first.
All sessions begin at 9:00 AM and 2:00 PM unless otherwise indicated.

1978 Scientific Assembly
Medical Association of Georgia
Southern Medical Association
World Congress Center, Atlanta, November 11-14

HOTEL	Single	Double	Twin	Suites	
				Parlor, One Bedroom	Parlor, Two Bedrooms
Hyatt Regency Atlanta 265 Peachtree Street, N.E.	$33.00- $47.00	$43.00- $57.00	$43.00- $57.00	—	$145.00- $350.00
Omni International Hotel One Omni International	$40.00- $55.00	$50.00- $65.00	$50.00- $65.00	$ 90.00- $185.00	—
Peachtree Plaza Hotel Peachtree at International Boulevard	$36.00- $49.00	$46.00- $59.00	$46.00- $59.00	$120.00- $180.00	$180.00- $260.00

SMA POSTGRADUATE COURSES
ATLANTA, GA.

Saturday, November 11, 1978

Course Number

1 **Gynecologic Oncology**—J. Max Austin, Jr., MD, Birmingham, Ala., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

2 **Update in Reproductive Endocrinology and Infertility (American Fertility Society)**—Charles B. Hammond, MD, Durham, N.C., Course Director, Fee: $100 (9:00 a.m.-5:00 p.m., Atlanta Hilton Hotel)

3 **Liver Disease**—John T. Galambos, MD, Atlanta, Ga., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

4 **Cardiology**—Arnoldo Fieodtin, MD, Atlanta, Ga., Course Director, Fee: $65 (9:00 a.m.-5:00 p.m.)

5 **Care of the Multiple Injured Patient**—Joseph A. Moylan, MD, Durham, N.C., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

6 **Problem Case Seminar on Common Hand Injuries: Basic and Advanced Techniques**—Ira M. Dushoff, Jacksonville, Fla., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

7 **Evaluation of Blood Transfusion Complications**—Ali A. Hossaini, MD, PhD, Richmond, Va., Course Director, Fee: $30 (2:00-5:00 p.m.)

8 **Head and Neck Surgery**—Fred M. S. McConnel, MD, Atlanta, Ga., Course Director, Fee: $30 (2:00-5:00 p.m.)

Sunday, November 12, 1978

9 **Maxillofacial Surgery**—Kenneth D. Salyer, MD, Dallas, Tex., Course Director, Fee: $30 (9:00 a.m.-12:00 noon)

10 **Acne**—Dan K. Chalker, MD, Augusta, Ga., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

Course Number

11 **Diagnosis and Clinical Management of Verrucae**—Beverly B. Sanders, Jr., MD, Macon, Ga., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

12 **Common Actinic Damage of the Skin**—Tom J. Meek, Jr., MD, Baton Rouge, La., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

13 **Medical Otolaryngology: Current Concepts in the Treatment of Common Disorders**—Robert L. Baldwin, MD, Birmingham, Ala., Course Director, Fee: $30 (2:00-5:00 p.m.)

Monday, November 13, 1978

14 **Pediatric Urology**—Michael P. Small, MD, Miami Lakes, Fla., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

15 **Dermatology for the Non-Dermatologist**—Franklin S. Glickman, MD, Brooklyn, N.Y., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

16 **Pediatric Dermatology**—Guinter Kahn, MD, North Miami Beach, Fla., Course Director, Fee: $40 (1:00-5:00 p.m.)

All courses fully accredited by the Council on Medical Education of the American Medical Association and are acceptable for hour-for-hour Category I credit toward the Physician's Recognition Award.

You may register for postgraduate courses by using the form in the front of the Preliminary Program which appears in the August issue of the *Journal*.

All courses will be held in the Georgia World Congress Center, unless otherwise designated.

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The callouts on the photograph below highlight the most important ways in which Mooney was able to derive a little over 1 mph top speed for each horsepower. **Epps Air Service** will be glad to show you these design features on the real thing... **a new 201.**

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Leakage drag is caused by air flowing to areas where you don't want it to go. For example, high air pressure from the bottom of the wing "leaking" through flap or aileron gaps to the lower pressure top of the wing results in some drag from the leakage flow itself. In addition, the leakage flow exits the leakage path and disturbs the primary flow causing more drag. Gap seals on flaps and control surfaces reduce the 201's leakage drag and provide for better control as well.

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MEDICAL MEETING CALENDAR

SEPTEMBER

28-30—*Jekyll Island;* **IMPROVING PHYSICIAN-STAFF INTERPERSONAL COMMUNICATIONS;** Category 1 Credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

29-October 1—*Pine Mountain;* **PHYSICIAN RECRUITMENT CONFERENCE AND PRE-PRACTICE SEMINAR SPONSORED BY MAG AND SOUTHEASTERN INSTITUTE FOR COMMUNITY HEALTH;** Contact: Gerard Hummel, P.O. Box 1708, LaGrange 30241. PH: 404/637-6646.

29-October 1—*Savannah;* **GEORGIA HEART ASSOCIATION ANNUAL MEETING AND SCIENTIFIC SESSIONS;** Contact: Georgia Heart Association, 2581 Piedmont Rd., Atlanta 30324. PH: 404/261-2260.

OCTOBER

4-5—*Charlotte, NC;* **ANNUAL CHARLOTTE POSTGRADUATE SEMINAR;** Contact: Richard Kerecman, M.D., P.O. Box 795, Huntersville, NC 28078.

5-8—*St. Petersburg, FL;* **14TH ANNUAL MEETING ON PROSPECTIVE MEDICINE AND HEALTH HAZARD APPRAISAL;** Category 1 Credit; Contact: Ronald Blankenbaker, M.D., College of Medicine, Box 13, Department of Family Medicine, 12901 North 30th St., Tampa, FL 33612.

6-7—*Atlanta;* **RADIOLOGY OF THE SMALL AND LARGE BOWEL;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

7-8—*Pine Mountain;* **GEORGIA GASTROENTEROLOGIC SOCIETY ANNUAL MEETING;** Contact: Joseph W. Griffin Jr., M.D., 212 Avondale Dr., Augusta 30907. PH: 404/828-2238.

17-28—*Various Ports;* **GYNECOLOGY AND OBSTETRICS ON THE MEDITERRANEAN;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

11-14—*Pine Mountain;* **PSYCHIATRIC INSTITUTE ON GROUP BEHAVIOR AND GROUP LEADERSHIP;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

12-13—*Augusta;* **NUTRITION;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

13—*Atlanta;* **6TH ANNUAL CARDIAC REHABILITATION SYMPOSIUM;** Contact: Gerald F. Fletcher, M.D., 300 Boulevard, N.E., Atlanta 30312.

13-15—*Atlanta;* **GENITO-URINARY SEMINAR;** Category 1 Credit; Contact: American College of Radiology, 20 North Wacker Dr., Chicago, IL 60606.

13-15—*Atlanta;* **THE SECOND HUMAN HAIR SYMPOSIUM;** Contact: Foundation for Gynecologic Oncology, 960 Johnson Ferry Rd., N.E., Suite 350, Atlanta 30342.

16-20—*Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

16-20—*San Francisco, CA;* **AMERICAN COLLEGE OF SURGEONS CLINICAL CONGRESS;** Category 1 Credit; Contact: C. Rollins Hanlon, M.D., 55 East Erie St., Chicago, IL 60611.

17-20—*Atlanta;* **WORKSHOP ON PRACTICE MANAGEMENT AND PRODUCTIVITY (OB-GYN AND ORTHOPAEDIC SURGERY);** Category 1 Credit; Contact: Conomikes Associates, 4270 Promenade Way, Suite 122, Marina del Rey, CA 90291. PH: 800/421-6512.

18-22—*Charleston, SC;* **VALVULAR DISEASE — PRACTICAL DIAGNOSIS AND MANAGEMENT;** Contact: Mary Anne McInerny, American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20014.

20-22—*Atlanta;* **STRESS, PSYCHOLOGICAL FACTORS, AND CANCER;** Contact: Dr. M. E. Milliken, Center for Health Occupations — Professional Services, Box 5403, Athens 30604.

20-22—*Asheville, NC;* **AMA REGIONAL MEETINGS FOR A VARIETY OF MEDICAL SPECIALISTS;** Contact: AMA Department of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6503.

21-22—*Atlanta;* **MAGNET (MAG NEW EDUCATION TRAINING);** Contact: Ken Williams, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

21-26—*Chicago, IL;* **ANNUAL MEETING, AMERICAN ACADEMY OF PEDIATRICS;** Contact: American Academy of Pediatrics, P.O. Box 1034, Div. M, Evanston, IL 60204.

21-26—*New Orleans, LA;* **89TH ANNUAL MEETING, ASSOCIATION OF AMERICAN MEDICAL COLLEGES;** J. A. D. Cooper, M.D., 1 DuPont Circle, N.W., Washington, D.C. 20036.

27—*Pine Mountain;* **SYMPOSIUM OF RHEUMATIC DISEASES;** Category 1 Credit; Contact: Dr. John Vansant, The Medical Center, Columbus 31902.

27-28—*Atlanta;* **4TH INTERDISCIPLINARY SYMPOSIUM ON CANCER-RELATED PROBLEMS;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

27-28—*Savannah;* **SOUTHEASTERN REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Nicholas E. Davies, M.D., 35 Collier Rd., N.W., Atlanta 30309.

27-29—*Atlanta;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 Credit; Contact: International Medical Education Corporation, 64 Inverness Dr. East, Englewood, CO 80110.

30-November 4—*Atlanta;* **ANNUAL MEETING, GEORGIA ACADEMY OF FAMILY PHYSICIANS;** Contact: GAFP, 11 Corporate Square, Suite 205, Atlanta 30329. PH: 404/321-7445.

NOVEMBER

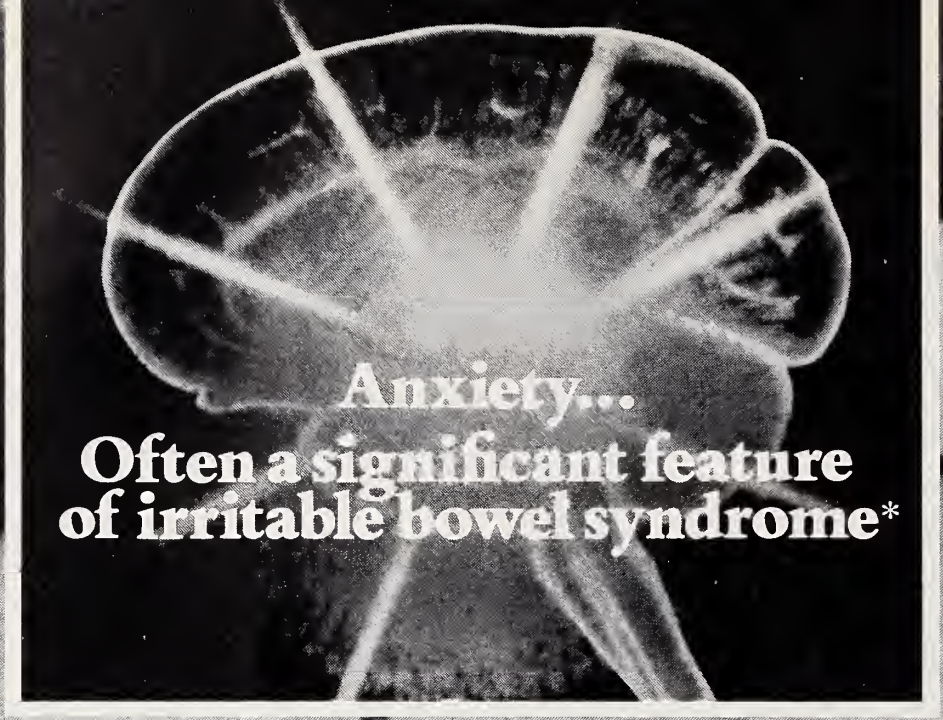
2—*Atlanta;* **PRACTICAL MANAGEMENT OF INFECTIONS IN THE NEWBORN AND YOUNG INFANT;** Category 1 Credit; Contact: James S. Maughon, M.D., 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211.

3-4—*Atlanta;* **PHYSIOLOGIC SYSTEM UPDATE;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

6-9—*Augusta;* **LAPAROSCOPY AND COLPOSCOPY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

11-14—*Atlanta;* **MAG-SOUTHERN MEDICAL ASSOCIATION ANNUAL SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Sue McAvoy, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug

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As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Letters to the Editor

HMOs and IPAs

Dear Sir:

Pursuant to the article on "Individual Practice Associations" by Robert N. Berg, Esq., in the June 1978, issue of the *Journal*, I feel that Mr. Berg has overlooked one of his basic responsibilities as general counsel to the Medical Association of Georgia. In his article on IPAs he has a paragraph entitled, "What Are the Advantages of Establishing an IPA?" As the impartial legal advisor to MAG it would be most appropriate for him to add a paragraph to his article entitled, "What Are the Disadvantages of Establishing an IPA?" Failure to do so appears to place Mr. Berg in a position of advocating that the Medical Association of Georgia establish this HMO-IPA concept and, therefore, would raise the question of thoroughness of his analysis.

I hope that you can get Mr. Berg to supply this information for the next issue of the *Journal*.

W. Daniel Jordan, M.D.
Decatur

The Author Replies

Since we have written four separate Journal *articles in the past five years on the topic of HMO's, we felt confident that most readers were conversant with the arguments, both pro and con, regarding HMO's. Our purpose in writing the June article was neither to reiterate nor advocate on those issues, but rather to explain the particular advantages envisioned by those now recommending that doctors who contract with HMO's do so through an IPA, rather than on an individual basis.*

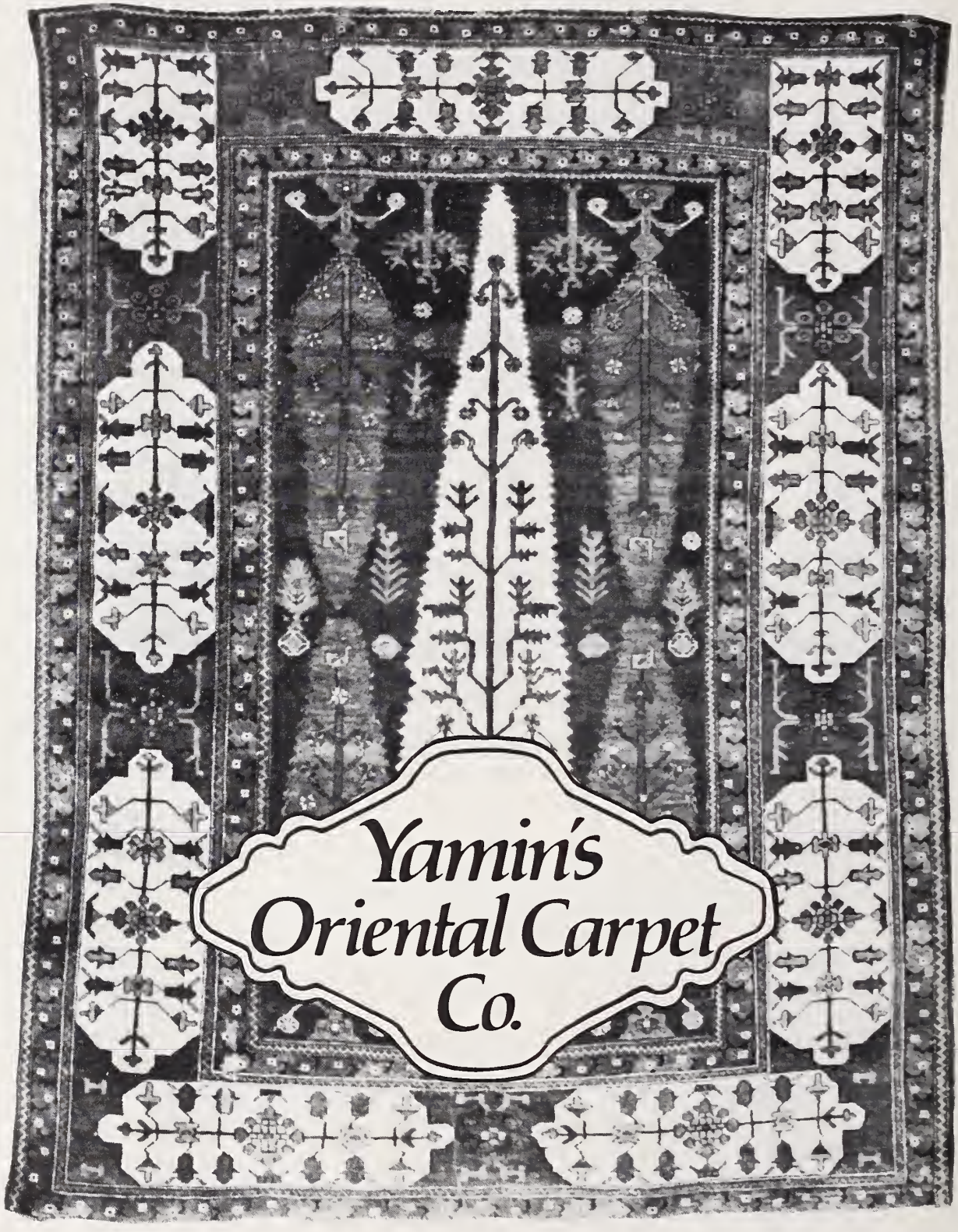
Our reading on this topic indicates that physicians may, in fact, have better bargaining strength if they deal with an HMO through an IPA. This concept is new, however, and disadvantages may become apparent in time.

Robert N. Berg
For Powell, Goldstein, Frazer & Murphy

We invite your response to the *Journal*

Send your letters to:

The Editor
Journal of MAG
938 Peachtree St., NE
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"Our Committee was quite surprised to find that a clear majority of (MAG members) . . . responding . . . favor mandatory CME in some form."

Introduction to Analysis of CME Survey: Food for Thought

LaMAR S. McGINNIS JR., M.D., *Decatur

At the 1977 Annual Session of the MAG House of Delegates, the Education Committee was directed to survey the members of the Association in regard to their feelings about the Scientific Assembly. Wishing to make the most of this opportunity, the Committee requested to be allowed to expand the survey to include many aspects of continuing medical education that were of interest to our Committee. This was approved by the Board of Directors, and a survey was developed and mailed to all MAG members.

The response to the survey by the MAG membership was most gratifying, with 1,705 replies (38%) being returned. Subsequently, a computer analysis of these surveys was made by the computer staff at MAG, and the Board of Directors has directed that the report of this analysis be published in the *Journal* for information to the membership and particularly for review and comment by those interested in continuing medical education. (That report follows this introduction.)

CME has been a "hot topic" in recent years, and many state medical associations have sought to evaluate the reaction of their membership to this burgeoning phenomenon. Alabama, Kansas, Connecticut and Pennsylvania are among the states that have conducted such surveys. The responses have been generally disappointing in the number of those responding, and we were therefore quite delighted to find such an interest among the membership of the MAG.

Our survey was divided into three main topic areas: (A) Mandatory CME; (B) the Scientific Assembly, and (C) other CME activities. In order to fully evaluate the results of the response, I request that you read the entire special report regarding the computer analysis. It is interesting to note that the responses came from a wide sampling of areas, including large, medium and small cities and from a wide range of specialties. The great majority of respondents are in private practice, with only 12% in institutional practice. Therefore, we feel that the survey represents a good and adequate sample of the membership and is valid. Some might say that only those interested in CME would reply to the survey, to which I would reply that also those opposed to CME could and did use this same vehicle to express their feelings.

The first three questions of the survey dealt with the question of mandatory CME. Our Committee was quite surprised to find that a clear majority of those responding, from throughout the state, favor mandatory CME in some form. It was evident that there was a wide disparity of recommendations in this regard; however, most members favor recertification and specialty society membership as the point at which they would wish their CME efforts to be focused.

The next series of questions related to the Scien-

* Chairman, MAG Education Committee. Dr. McGinnis' address is 365 Winn Way, Decatur, GA 30030.

tific Assembly, and it was gratifying to note that there was an overwhelming support of the Scientific Assembly by those who had attended one or more of these programs during the years 1975, 1976 and 1977. It was also apparent that a large number of the respondents had not attended any of these Scientific Assemblies. At any rate, the Association as a result of this survey has now given full support to the Scientific Assembly, and it apparently will continue and should grow in strength.

The final series of questions called for some narrative answers, and the Education Committee is in the process of evaluating them. It is of interest to note that the weekends are the most popular times for programs and that the preferred sites are Atlanta and vacation areas in Georgia. Over 1,200 respondents wrote down suggestions for CME program topics, and these were almost universally related to the specialty of the respondent. The Scientific Assembly, a forum for programs planned by the specialty societies, would therefore seem to be on a sound basis. Without question, the most highly used and popular form of CME continues to be the reading of journals and books, with consultation or discussion with colleagues, in-hospital programs, and scientific meetings sponsored by specialty societies ranking next in popularity. Virtually all respondents practicing in hospitals with approved CME programs rated these in-hospital activities high on their list of favored CME activities.

The questions requiring narrative answers are at present being analyzed by members of the Education Committee and should continue to provide useful information to assist in planning programs, choosing topics and sites, and in general improving the quality of continuing medical education.

As a result of this survey, the Education Committee feels even more strongly that all hospitals with over 100 beds should strive to develop an approved program of CME. Resources are readily available through the medical schools and through the MAG to assist in the development of these programs. Our goal is to have quality CME at the local level where it is readily accessible to the practicing physician. MAG's House of Delegates, at its Annual Session in 1979, will further evaluate the responses to this survey and take any action it deems appropriate.

The Education Committee of the MAG is of the opinion that the time, effort and money spent in developing and analyzing this survey was most worthwhile. Your comments and opinions regarding any aspect of the information brought to light would be most appreciated.

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SUSAN KATZ DESIGN ASSOCIATES

Analysis of MAG Survey on Continuing Medical Education

STEPHEN L. DANIEL, Ph.D., *Atlanta**

In January 1978, the Medical Association of Georgia's Division of Education conducted a survey of the entire MAG membership on the subject of continuing medical education. Four thousand five hundred and five questionnaires were mailed out, and 1,705 or 38% were completed and returned — a statistically valid sampling and an excellent response for surveys of this kind. (A copy of the survey follows this analysis.)

Respondents were classified by geographical location (zip code), specialty and type of practice. Almost half (44%) are from the Atlanta area, with the remainder equally distributed among larger, medium-sized and smaller cities. For the purpose of the survey, Augusta, Columbus, Macon and Savannah are treated as larger cities and the following as medium-sized cities: Albany, Athens, Brunswick, Dalton, Gainesville, LaGrange, Rome, Thomasville, Valdosta, Waycross. (See Table 1.)

All specialties are represented among the respondents, with the greatest number in internal medicine, general surgery, family practice and obstetrics-gynecology. Internal medicine includes the subspecialties of cardiology, gastroenterology, oncology, chest diseases, etc. General practice is treated separately from the specialty of family practice. (See Table 2.)

Eighty-four percent of the respondents are either in solo practice or in partnership or group practice. The remainder are either in institutional practice or not in practice. (See Table 3.)

Mandatory Continuing Medical Education

The first three questions of the survey were designed to determine whether the members are in favor of making continuing medical education mandatory and, if so, what the preferred forms of requirement are.

Question 1 assumes that physicians in Georgia will soon be required to give proof that they are continuing their education and/or maintaining their skills, and it asks what this proof should be based on. Thirty-two (1.9%) of the respondents favor periodic examination only, 695 (41.7%) favor participation in CME activities only, 132 (7.9%) favor patient care evaluation only, and 809 (48.5%) favor some combination of these choices.

Question 2 asks whether the respondents are opposed to or in favor of mandatory CME. Significantly, and not according to the expectation of the survey's sponsors, only 394 (23.1%) are opposed to all forms of mandatory CME, whereas 1,044 (61.2%) favor some form of it. Two hundred forty-

* MAG's Assistant Executive Director—Education.

five (14.4%) are neither opposed to nor in favor of mandatory CME, and 22 (1.3%) did not answer the question. The response did not vary significantly with geographic location. (See Table 4.)

When the physician's specialty is taken into account in the response to Question 2, there is little difference between the major specialties of internal medicine, general surgery and obstetrics-gynecology. A relatively greater percentage of family physicians, radiologists and neurosurgeons favor some form of mandatory CME. This may be explained by the fact that these three groups have CME requirements for membership in their national specialty societies. Less than half of those who call themselves general practitioners and an even lower percentage of allergists, otolaryngologists and dermatologists are in favor of mandatory CME. (See Table 5.)

Question 3 is conditional: "If CME is to be mandatory, what do you prefer to see it tied in with?" Stated otherwise, what form of mandatory CME is preferable? Each respondent was free to select one or more of the choices given. Table 6 includes all responses in order of preference.

When geographic area is taken into account, the only significant variations from Table 6 are among physicians from smaller towns, whose preferences, in order, are membership in MAG (29.8%), recertification (21.9%), hospital staff privileges (21.0%), membership in specialty society (21.0%), relicensure (17.6%), peer review (9.7%), no preference (7.6%), and other (4.3%).

The physician's specialty makes a greater difference in the preferred forms of mandatory CME. For example, 48.5% of the general practitioners prefer membership in MAG and 27.9% prefer hospital staff privileges, whereas only 1.5% prefer recertification and only 5.9% prefer membership in their specialty society. The results for family practitioners, on the other hand, are 41.1% for recertification, 20.6% for membership in specialty society, 18.9% for hospital staff privileges, and 18.9% for membership in MAG. Fifty-one percent of the pediatricians and 50.0% of the dermatologists prefer recertification, whereas only 12.6% of the psychiatrists prefer this form. Forty-eight and five-tenths percent of the psychiatrists and 49.4% of the orthopaedic surgeons prefer linking mandatory CME to specialty society membership, while only 15.6% of the internists favor this form.

TABLE 1

DEMOGRAPHIC BREAKDOWN OF RESPONDENTS

	Number Responding	Percentage of Total
Atlanta area	722	43.9
Larger cities	335	20.4
Medium-sized cities	248	15.1
Smaller cities	329	20.0
Out of state	12	.7

TABLE 2

BREAKDOWN OF RESPONDENTS BY SPECIALTY

	Number Responding	Percentage of Total
Allergy	9	.5
Anesthesiology	56	3.3
Dermatology	24	1.4
Emergency medicine	15	.9
Family practice	175	10.3
General practice	68	4.0
General surgery	180	10.6
Internal medicine	275	16.1
Neurology	20	1.2
Neurosurgery	21	1.2
Obstetrics-Gynecology	150	8.8
Ophthalmology	70	4.1
Orthopaedic surgery	85	5.0
Otolaryngology	42	2.5
Psychiatry	103	6.0
Pediatrics	100	5.9
Public Health	15	.9
Preventive medicine	2	.1
Plastic surgery	24	1.4
Pathology	49	2.9
Radiology	92	5.4
Urology	50	2.9
Unspecified	80	4.7

TABLE 3

BREAKDOWN OF RESPONDENTS BY TYPE OF PRACTICE

	Number Responding	Percentage of Total
Solo	684	41.3
Partnership or group	726	43.8
Institution	195	11.8
Not in practice	52	3.1

Discussion

One of the most important results of the survey is the uncovering of the fact that a clear majority of MAG members throughout the state favors mandatory continuing medical education. The real question, therefore, is with what mechanism mandatory CME should be linked. The choices are relicensure, recertification, membership in the MAG, specialty society membership, hospital staff privileges, and peer review.

MAG members are most in favor of recertification and specialty society membership and least in favor of relicensure and peer review. It is apparent that

TABLE 4

ATTITUDE TOWARD MANDATORY CME BY GEOGRAPHIC AREA

	Opposed %	In Favor %	Indifferent %
Atlanta area	24.2	60.0	14.3
Larger cities	20.9	62.4	15.8
Medium-sized cities	18.1	63.7	17.7
Smaller cities	24.6	62.9	11.2

TABLE 5

ATTITUDE TOWARD MANDATORY CME BY SPECIALTY

	Opposed %	In Favor %	Indifferent %
Allergy	33.3	44.4	22.2
Anesthesiology	17.9	66.1	16.1
Dermatology	29.2	37.5	33.3
Emergency medicine	20.0	53.3	26.7
Family practice	22.3	66.3	10.9
General practice	32.4	47.1	19.1
General surgery	25.6	62.8	11.1
Internal medicine	25.5	59.3	13.8
Neurology	25.0	65.0	5.0
Neurosurgery	23.8	71.4	4.8
Obstetrics-gynecology	24.7	59.3	15.3
Ophthalmology	20.0	65.7	12.9
Orthopaedic surgery	16.5	69.4	14.1
Otolaryngology	31.0	40.5	21.4
Psychiatry	21.4	57.3	20.4
Pediatrics	19.0	70.0	11.0
Public health	6.7	60.0	26.7
Preventive medicine	0.0	50.0	50.0
Plastic surgery	33.3	54.2	12.5
Pathology	22.4	63.3	12.2
Radiology	9.8	73.9	14.1
Urology	22.0	60.0	18.0

TABLE 6

PREFERRED VEHICLE FOR MANDATORY CME

	Number Responding	Percentage of Total
Recertification in specialty	489	28.7
Membership in specialty society	456	26.7
Membership in MAG	345	20.2
Hospital staff privileges	334	19.6
Relicensure	286	16.8
Peer review	265	15.5
No preference	126	7.4
Other (specified)	56	3.3

they would rather have their CME requirements administered by their specialty board or society rather than by the state government or a peer review organization such as a PSRO.

The choices of recertification and specialty society membership cannot be implemented on a universal basis, since, as of early 1978, only one specialty board (family practice) and seven national specialty societies have CME requirements. Major specialties without national requirements are internal medicine, surgery, obstetrics-gynecology and pediatrics. The American Board of Surgery will implement a CME requirement in 1986. General practitioners, of course, are not represented by a specialty board or society.

Since all 22 medical specialty boards have established policies to provide recertification, an alternative approach might be for the MAG or, less preferably, the State Board of Medical Examiners to require all eligible specialists to show proof of recertification on a periodic basis. Physicians who are not eligible for recertification would have to be treated separately. For those who are members of specialty societies with CME requirements, proof of membership might be required. For the rest, equitable CME requirements would have to be established by the MAG or the State Board of Medical Examiners.

Georgia is one of only 13 states which have not established, by early 1978, a CME requirement for relicensure or membership in the state medical society. This may well be to the benefit of our physicians, but, in light of the survey, the MAG membership should seriously consider supporting one or a variety of forms of mandatory CME.

Scientific Assembly

The 1977 MAG House of Delegates adopted a recommendation that the MAG membership be surveyed on the value of the annual MAG Scientific Assembly, its continuance, and alternative approaches for MAG to support continuing medical education. Survey questions 4-7 take up these matters.

Question 4 asks simply whether the respondent attended the 1975, 1976, and/or 1977 MAG Scientific Assembly. Five hundred and ninety-nine (35.7%) said that they did and 1,079 (64.3%) that they did not.

Question 5 solicits opinion on the value of the Scientific Assembly and whether or not it is a good expenditure of MAG funds. Taking all responses together, 36.3% think that the Scientific Assembly is worthwhile CME and a good expenditure of MAG funds, 6.4% that it has little or no value and is a poor expenditure of MAG funds, 12.7% that it has some value but could be improved in specified ways, and 44.6% that they don't know enough about it to give an educated opinion. When those attending a Scientific Assembly are considered separately as a group, 67.9% think the Assembly is worthwhile, 5.3% that it is of little or no value, 18.2% that it has some value, and 8.5% declined to give an opinion. By comparison, when those *not* attending a Scientific Assembly are considered separately, 15.1% think

the Assembly is worthwhile, 6.3% that it is of little or no value, 8.2% that it has some value, and 70.5% declined to give an opinion.

When the answers to Question 5 are correlated with geographic locations of the respondents, there are no noteworthy variations from the above figures. However, it should be noted that a relatively higher percentage of Atlanta area physicians think the Scientific Assembly is worthwhile, and a relatively higher percentage of non-Atlanta physicians do not know enough about it to give an opinion.

If the respondent's specialty is taken into account, there are some notable variations on Question 5. The Scientific Assembly is regarded as worthwhile by 40-60% of the internists, general surgeons, radiologists, pathologists and ophthalmologists and by only 5-20% of the psychiatrists, urologists, otolaryngologists, orthopaedic surgeons, dermatologists and anesthesiologists. It appears most significant that the latter groups (with the exception of psychiatry) have not sponsored regular scientific sessions at the Assembly, while all of the former groups have done so. Notable in this regard is that 32% of those in family practice, which sponsors its own Fall Scientific Session independently of the MAG meeting, think that the MAG Scientific Assembly is worthwhile. Of those who think the Assembly has little or no value, the highest percentage among specialties is that of the dermatologists (20.8%).

Question 6 asks whether the Scientific Assembly should be continued. Fifty-eight and one-tenth percent of all respondents say *yes*, 5.1% say *no*, and 36.8% expressed no opinion. The *yes* figure rises to 86% and the *no* figure falls to 4% when the group of those attending a Scientific Assembly is considered by itself. Geographic location and specialty have no significant effect on the response to this question.

Question 7 asks whether the MAG should spend the funds on other educational activities *if* the Scientific Assembly were to be discontinued. Thirty-nine and eight-tenths percent of the respondents are opposed to such expenditure, whereas 60.2% are in favor of it. A good number wrote down specific suggestions for educational activities worth funding, and the MAG Committee on Education will be considering these in the months ahead.

Discussion

Results of the survey indicate that the great majority of MAG members expressing an opinion support the annual MAG Scientific Assembly as a worthwhile form of CME and favor continued funding of it. This is especially true for those who have actually attended an Assembly or who practice in specialties which sponsor regular sessions at the Assembly. Considering that a great number of MAG members are apparently not familiar enough with the Assembly to proffer an opinion, the MAG Committee on Scientific Assembly might consider ways of increasing publicity and attendance at upcoming Assemblies.

Other Continuing Medical Education Activities

The MAG Division of Education is most interested in the continuing education activities, habits and preferences of all physicians in the state; and questions 8-16 of the survey were designed to ascertain this information. It will be used to help set program and budgetary priorities for educational activities sponsored by the MAG.

Questions 8-11 solicit the respondents' opinions on the preferred length of time, day(s) of the week, time of day, geographic locations and topics for formal CME programs. Almost half (47%) of the respondents replied that the ideal length of a program varies with the program, 18.9% prefer a 2-day program, 14.5% a 3-day program, 4.3% a 1-2 hour program, and 3.3% a half-day program. The preferred days of the week for a program are Saturday, Sunday, Friday and Thursday, in that order. The preferred times of day are 9-12 a.m. (52.0%), 12-5 p.m. (49.3%), 7-9 a.m. (18.5%) and 7-10 p.m. (16.4%). The preferred sites for programs are Atlanta (51.9%), vacation areas in Georgia (27.9%) and the town of the physician's practice (21.6%). One thousand two hundred and eighty-four respondents wrote down suggestions for program topics, and these will be tabulated by the MAG Division of Education.

Question 12 asks whether the physician participates in as many CME activities as he or she desires. Forty-six and six-tenths percent of the respondents say *yes*, and 53.4% say *no*. As might be expected, the percentage of *no*'s rises (to 68.4%) for physicians in smaller cities. The main obstacles to optimal participation in CME, as perceived, are lack of time (32.8%), scheduling conflicts (21.9%), excessive expense (18.9%), lack of coverage for practice (13.4%) and lack of convenient CME in a subject relevant to practice specialty (12.1%).

Questions 13 and 14 ask the physician both to list the types of CME activity most engaged in and to indicate their relative value. According to the responses, the most highly used forms of CME are, in order, the reading of journals and books, consultation or discussion with colleagues, in-hospital programs, scientific meetings sponsored by specialty societies, bedside rounds, committee work in patient care evaluation, teaching, audio-cassette tapes, patient education, the use of hospital library resources, and meetings sponsored by medical schools or medical societies. Less used forms are self-assessment exams, specialty board exams, audiovisual pro-

grams, preparation of written articles, correspondence courses, clinical traineeships, and dial access consultation programs. In-hospital programs are the most heavily utilized form of CME in Atlanta, Augusta, Columbus, Macon and Savannah, whereas scientific meetings sponsored by specialty societies are the most utilized form in medium-sized cities, and meetings sponsored by medical schools have the highest utilization in smaller cities. Overall, the most highly valued forms of CME are, in order, the reading of journals and books, consultation with colleagues, scientific meetings sponsored by specialty societies, meetings sponsored by medical schools, specialty board exams, use of hospital library resources, and teaching.

Question 15 asks the respondent what his or her single most valuable educational experience was during the past year. The responses are individually written and will be studied by the MAG Committee on Education.

The final question — question 16 — invites the respondent to make comments or suggestions which he or she thinks might be of value to the Education Committee. These too will be studied in detail.

Discussion

This final section of the survey provides a wealth of information which should keep the MAG Division of Education busy for some time in the task of planning the Association's CME priorities and programs. Computer analysis of the survey makes it possible to study the members' needs and preferences city by city, hospital by hospital, specialty by specialty.

In establishing educational priorities, one should not overlook the continuing popularity of such tried and true forms of CME as the reading of medical journals, consultation with colleagues, and the scientific meeting sponsored by a specialty society or medical school. In-hospital CME programs, while highly utilized (especially in the larger cities), appear to be of mixed value, and the MAG Division of Education might devote special attention to helping the hospitals improve these programs. Newer methods of CME, such as video programs and self-assessment exams, are beginning to make their mark, and MAG's educational leaders might take a special look at their cost effectiveness and value in terms of time and convenience.

Finally, any consideration of CME requirements for whatever purpose should take account not only of physicians' preferences but of their actual practices and habits in continuing their education.

AMA's Malpractice Reinsurance Company Having Favorable Impact on World Market

In less that two years of operations, the AMA's American Medical Assurance Company has become an important factor in improving the availability and price of malpractice reinsurance, according to AMA sources.

When AMACO, a wholly owned subsidiary of the AMA, opened for business in the fall of 1976, reinsurance was difficult to obtain and competition was virtually nonexistent. Nearly all available reinsurance came out of London and on London's terms. Today, the indicators point to a softer market demonstrated by new increases in obtainable limits and by competition for the business between the U.S. and London.

A new era of competitive bidding has replaced the "seller's" market of less than two years ago. Consequently, the 18 operating medical society-created companies in the country are in a better position to pick and choose and to accept the reinsurance proposal that best meets their needs and pocketbook.

AMACO, which deals exclusively with medical society companies, was funded with $5 million from the AMA. The action followed two years of technical study and hours of consideration by the AMA's House of Delegates. AMACO now has assets of $7 million. The company is involved with a portion of the reinsurance programs for nine approved companies, covering more than 40,000 physicians.

AMACO's primary objective as mandated by the House of Delegates was to encourage the development of a more equitable and reasonably competitive re-insurance market on a commercially sound basis. The young company is fulfilling that objective, AMA said.

Cystic Fibrosis Foundation Awards Three Grants to Emory University

Emory University has been awarded three grants totaling nearly $50,000 to support research, clinical care, and physician training in cystic fibrosis and other pediatric lung and digestive diseases in 1978-79. The grants are from the Cystic Fibrosis Foundation.

The Emory School of Medicine will receive $21.129 for its Cystic Fibrosis Center located at Grady Memorial Hospital. This center specializes in the diagnosis and treatment of cystic fibrosis and related diseases. A lung-damaging disease which also can affect digestion, cystic fibrosis takes more children's lives in the United States than any other genetic disorder.

The Cystic Fibrosis Center at Grady provides highly specialized care for children from across the state. It is the 10th largest of 120 clinics in the nation with standards of health care approved by the CF Foundation.

Though cystic fibrosis is not yet curable, advances made at CF clinics in diagnosis and treatment of the respiratory and digestive complications of the disease have greatly improved the quality and length of the CF-affected child's life.

MAG QUESTIONNAIRE ON EDUCATION

PLEASE RETURN BY JANUARY 10, 1978
(Please print or type)

Name: _____

Address: _____

_____ Zip _____

Specialty _____

Type of Practice: ☐ Solo ☐ Partnership or Group ☐ Institution ☐ Not in practice

Primary Hospital: _____ Size: _____ Beds

1. The pressure for assurance of quality of health care may lead soon to a state requirement for proof that physicians continue their medical education and/or that they maintain their skills. Assuming the above, in your estimation such proof should be based on:
   - ☐ Periodic examination only (e.g., once every 6 years.)
   - ☐ Participation in CME activities only (e.g., 150 hrs. every three years.)
   - ☐ Patient care evaluation only (e.g., participation in medical audits)
   - ☐ Some combination of the above

2. Which statement correctly reflects your view:
   - ☐ I am opposed to *all* forms of *mandatory* continuing medical education.
   - ☐ I am in favor of *some* form of mandatory CME.
   - ☐ I am neither opposed to nor in favor of mandatory CME.

3. *If continuing medical education is to be mandatory,* I prefer that it be tied in with:
   - ☐ periodic re-registration of my license to practice medicine
   - ☐ membership in Medical Association of Georgia
   - ☐ periodic re-certification in my specialty
   - ☐ membership in my specialty society
   - ☐ hospital staff privileges
   - ☐ peer review
   - ☐ other (specify) _____
   - ☐ no preference

4. I attended the 1975, 1976, and/or 1977 MAG Scientific Assembly. ☐ yes ☐ no

5. My opinion of the annual MAG Scientific Assembly is that
   - ☐ It is worthwhile CME and a good expenditure of MAG funds.
   - ☐ It has little or no value and is a poor expenditure of MAG funds.
   - ☐ It has some value but could be improved by _____
   - ☐ I don't know enough about it to give an educated opinion.

6. The Scientific Assembly should be continued. ☐ yes ☐ no ☐ no opinion

7. If the Scientific Assembly were to be discontinued, I suggest that
   - ☐ the MAG *not* spend the funds on educational activities.
   - ☐ the MAG spend the funds on the following kinds of educational activities:

8. What is the best length of a worthwhile formal CME program *for you?*
   - ☐ 1-2 hrs. ☐ ½ day ☐ 1 day ☐ 2 days
   - ☐ 3 days ☐ 1 week ☐ varies according to program

9. Circle the day(s) of the week and time(s) most convenient for you to attend a formal CME program.

M	T	W	T	F	Sat	Sun				
							Morning:	7-9	Afternoon:	12-5
								9-12		5-7
							Evening:	7-10		

10. What geographic location(s) do you prefer for a formal CME program?
    - ☐ town or county of practice
    - ☐ Atlanta
    - ☐ other city (specify) _____
    - ☐ out of state
    - ☐ vacation area in Georgia
    - ☐ makes no difference

11. What topics for CME programs would be of most interest and value to you?

12. Are you able to participate in as many continuing medical education activities as you desire? ☐ yes ☐ no
    If *no*, please indicate the main obstacle(s) to your participation:
    - ☐ lack of CME opportunities in my geographic area
    - ☐ lack of convenient CME opportunities in subject relevant to my practice or specialty
    - ☐ available CME is of dubious quality
    - ☐ lack of time
    - ☐ too expensive
    - ☐ scheduling conflicts
    - ☐ difficult to get coverage for practice
    - ☐ other (specify) _____

13. Please indicate how often you engage in the following activities, and rate them in terms of their *educational* benefit to your professional life.

		Frequency of Use			Value		
		Often	Seldom	Never	High	Variable	Low
A.	In-*hospital* programs (tumor conferences, departmental or staff meetings, lectures, CPCs, etc.)						
B.	Meetings or courses sponsored by *medical schools*						
C.	Clinical traineeships or mini-residencies						
D.	Scientific meetings sponsored by national, state or local *specialty societies*						
E.	Meetings sponsored by *medical societies* (county, district, state, or AMA)						
F.	Committee work in patient care evaluation (medical audit, UR, etc.)						
G.	Bedside rounds						
H.	Consultation or discussion with colleagues						
I.	Reading of journals and books						
J.	Use of hospital *library* resources						
K.	Preparation of articles, papers, books, or exhibits						
L.	Self-assessment exams (including preparation and follow-up)						
M.	Specialty board exams (including preparation)						
N	Correspondence courses						
O.	Audio cassette tapes						
P.	Video cassettes, films, slides, and other audiovisual programs						
Q.	Teaching colleagues, housestaff, health personnel (including preparation)						
R.	Dial access consultation programs						
S.	Patient education and patient feedback						
T.	Other (specify) _____						
U.	_____						

14. Please indicate below in rank order by identifying letter (from above list) the 3 kinds of educational activity *most* engaged in by you.
    Activity (identify by letter)
    1.
    2.
    3.

15. What was the single most valuable educational experience you had last year? _____

16. Do you have any comments which you think might be of value to the MAG's Education Committee?

Signed _____

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ataxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, traphic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not promptly discontinue the preparation until adequate control by other antiinfectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, secondary infection, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptions, maceration of the skin, and hypopigmentation. Contact sensitivity to particular dressing material or adhesive may occur occasionally. Ototoxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also available in jars of 120 g. (4 oz.) for hospital or institutional use only.

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ctions: Pyrvinium amoate appears to exert s anthelmintic effect by eventing the parasite om using exogenous arbohydrates. The para- te's endogenous reserves e depleted, and it dies. ovan is not appreciably sorbed from the gastro- testinal tract.

dication: Povan is indi- ated for the treatment of nterobiasis.

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ecautions: To forestall ndue concern and help void accidental staining, atients and parents hould be advised of the aining properties of ovan. Care should be xercised not to spill the spension because it will ain most materials. ablets should be swal- wed whole to avoid aining of teeth. Parents nd patients should be formed that pyrvinium amoate will color the ool a bright red. This is ot harmful to the patient. emesis occurs, the omitus will probably be olored red and will stain ost materials.

dverse Reactions: ausea, vomiting, cramp- g, diarrhea, and hyper- nsitivity reactions (pho- sensitization and other llergic reactions) have een reported. The gastro- testinal reactions occur ore often in older chil- en and adults who have ceived large doses. mesis is more frequently en with Povan Suspen- on than with Povan lmseals.

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Thanks to this unusual set-up by a group of Georgia physicians, a community which previously was not served by a physician now has 24-hour coverage for all patients.

Rural Family Practice Group Satellite Office Model

ADAM R. JABLONOWSKI, M.P.A., *Atlanta**

ACCESS TO MEDICAL CARE, particularly in rural and inner city areas has been a problem for a number of years. (Only the rural situation will be dealt with here.) A major factor in creation of this problem has been the declining number of family physicians trained in the United States over the past 30 to 40 years. As an aging population of general practitioners retired and was not replaced, more and more communities found themselves in the position of being medically underserved or unserved. Although family physicians, but more likely other specialists, might be available in nearby communities, for many rural residents the departure of their family physician meant loss of access to medical care except for emergencies attended to at the nearest hospital emergency room.

At both the federal and state government levels, a number of programs were developed to provide medical services to underserved areas: National Health Service Corps, Rural Health Initiative, Health Access Stations and Primary Care Centers. Whether directly or indirectly dealing with a shortage area, the government solutions were in many cases unsatisfactory. NHSC personnel were not retained beyond their commitment. Alternative delivery systems using non-physician providers did not satisfy the communities' desires for the presence of family physicians to respond to their perceived need for personal, continuing and comprehensive medical care.

Although a number of groups recognized the crisis occurring in medical care delivery with the decline in the number of general practitioners in the U.S., it was not until 1969 that a definitive move was made in an effort to correct the situation. With the rebirth of general practice as a new specialty — family medicine — and the establishment of three-year family practice residency programs to train young physicians, there was finally a chance to make a positive impact on the access problem. Because of the long-start-up inherent in developing a training program and the duration of the training itself, it has not been until recent years that graduates of the programs have been entering practice.

In Georgia, the first training program was established in 1972 at The Medical Center in Columbus. Programs were then begun at Augusta in 1973, at Macon in 1974, at Rome in 1975 and Savannah in 1977.

The number of graduates from Georgia's programs are listed below:

	1975	*1976*	*1977*	*1978**
Augusta	2 (1)	1 (1)	2 (2)	6 (4)
Columbus	2 (2)	4 (2)	13 (6)	6 (2)
Macon	0	3 (3)	2 (2)	3 (3)
Rome	0	0	0	1 (1)
Savannah	0	0	0	0
Total	4 (3)	8 (6)	17 (10)	16 (10)

* Data through July 31, 1978; (#) represents graduates practicing in Georgia.

* Administrator, Joint Board of Family Practice, 6065 Roswell Rd., NE, Atlanta, GA 30328.

These family physicians practice in communities of various size:

Rural	
Under 5,000	10
Under 20,000	10
Small Urban	
Under 50,000	1
Under 100,000	5
Suburban	1
Metropolitan	2

Of the 45 graduates, 29 established practices in Georgia. With an increase in the percentage of MCG and Emory graduates entering family practice, the number remaining in Georgia is expected to increase significantly.

The Satellite Model Office

The remainder of this discussion will be devoted to describing an interesting practice arrangement which has emerged in Southeast Georgia as the result of the addition of three family practice residency graduates to a previously solo practicing family physician's office. Although this type of occurrence may not be replicable in a number of other similar sites in the state, it offers a model which could be responsive to the access needs of rural communities located in reasonable proximity to a group of family physicians.

Up until December of 1976, the five family physicians and two general surgeons of Jesup, Georgia, served the population of their own county (Wayne, 19,000) as well as portions of five adjacent counties (Appling, Tattnall, Long, Brantley and Pierce) with a total population of 51,500 and 11 physicians. Appling, Brantley, Long, Pierce and Tattnall counties have been listed by DHEW as critical medical shortage areas as well as being medically underserved areas, the latter designation by the Southeast Georgia HSA.

In January of 1977, a solo family practitioner, practicing in Jesup since 1961, formed a group practice, hiring three Macon family practice residency program graduates. This unusual, perhaps unique, occurrence resulted from the desire of the three to practice together in a rural community and the desire of the solo practitioner to obtain assistance with his heavy patient load as well as to deal with the unmet demand for medical care in the area. Fortunately for all concerned, the group has been able to attract a sufficient patient population to allow for an economically viable group practice. This is particularly noteworthy because of the number of new physicians involved and the short time period in which the group has been able to meet their increased costs and break even. Such an early achievement permitted the group to turn its attention to a request for physician services from a nearby community.

The town of Nahunta, 30 miles south of Jesup in Brantley County, has been unable to recruit a full-time physician. Since the late 1950's, the town has had a Sears Roebuck Foundation Medical Clinic, owned by the Brantley County Development Authority. Over the years a succession of foreign medical graduates and part-time physicians have practiced in the Clinic for generally short periods of time. All have left for one of several reasons — insufficient patient volume, dissatisfaction with the area, moved to larger community and so on.

In January of 1977, Nahunta's druggist, who was leasing the clinic, contracted with the Wayne Family Practice Association to staff the town's "Medical Center." The Authority agreed to an arrangement whereby the Center would provide physician services on Mondays, Wednesdays and Fridays from 11:00 a.m. to 5:00 p.m. The remainder of the time, a telephone answering device refers patients to a Jesup number for the group, thereby ensuring that 24-hour coverage is available to all patients. The Center staff includes an LPN and a receptionist. Modified problem-oriented medical records are maintained at the site, while billing is conducted from the Jesup office. In order to maintain continuity of care, patients are scheduled for appointments with their own physicians. Drop-in patients are accepted and seen between regular appointment scheduled patients. Patients requiring hospitalization are sent to Jesup unless more extensive care is required, in which case hospitalization would be in Brunswick, Waycross or Savannah.

"Although this model may not be readily replicable in all other medically underserved areas of Georgia, it merits careful consideration."

Nahunta's population is about 2,000 with a total of 7,500 for the county. The Center is currently averaging 30 patients per day with two to three hospitalized patients in Jesup. About 25% to 30% of the patients are Medicare and/or Medicaid eligible. Prior to the opening of the Center, these patients were utilizing physicians in Jesup, Waycross, Folkston or Brunswick, primarily on a crisis care basis.

Although the community leadership would have preferred a full-time physician residing in Nahunta, they seem to be satisfied with the present arrangement. The local women's clubs have arranged for an open house at the Center for the town's residents to meet the doctors and to familiarize the people with the facility and its operations.

Working arrangements have been developed with the local public health nurse and welfare representatives to assist their clients requiring medical services. The initiation of the physicians' practice at the Center has obviated the DHR's need to establish a primary health center in Nahunta in order to attempt to meet the medical needs of the community.

Thus far, the physicians in surrounding areas have not indicated any concern over the Center causing any loss of patients. This may be due to the overcrowded situation in their offices as well as the Center's seeing patients who would not otherwise visit a physician because of the unavailability of transportation.

In conclusion, the opening of the Nahunta Medical Center may be said to have benefitted the residents of the town, the physician group, the local government and DHR. The town's people are obviously better medically served with the relatively immediate access to physician care in town for ambulatory services and in Jesup for hospitalization. The physician group has expanded its patient population and thus increased its potential for income production as well as that for the Jesup hospital. The local governing authorities can be satisfied that they have successfully filled the need for medical care in their community. With the availability of physicians in the Center, DHR can make use of their services for clients referred and it no longer is required to consider the establishment of a primary care center with its attendant cost.

Although this model may not be readily replicable in all other medically underserved areas of Georgia, it merits careful consideration by community leaders and rural physicians. In areas with established group practices or where such a practice could function, it may be possible to extend the services of the group to nearby communities desiring physician services and willing to accept them on the satellite office model basis.

Acknowledgement

The assistance of Drs. Ollie McGahee and Irwin Streiff in the preparation of this material is greatly appreciated.

Williams

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Schistosomiasis: What Do You Remember about It?

WILLIAM J. MORTON, M.D., *Atlanta

THE LAST TIME I even thought about schistosomiasis may have been when I was studying for my boards. I can't even remember whether there was a question about it on the exam. But, recently, I had to go back to the books again because I had a real-life, documented, "I-made-the-diagnosis-myself" case. The purpose of this article is not to present some vague esoteric scientific diagnostic dilemma, but merely to expose the reader to the suggestion that we in this country may be seeing more of this very common worldwide disease and to refresh all of ourselves about its epidemiology, life cycle, pathogenesis and clinical course.

S.R., a 22-year-old Saudi Arabian Oglethorpe student was seen by his internist for rather vague lower abdominal pain. The history and physical examinations were within normal limits as were all laboratory studies except that microscopic hematuria was noted. An intravenous pyelogram (Figs. 1 and 2) was obtained, and he was referred for further urological evaluation. He was admitted to the hospital, urine and stool were examined for ova and parasites, and at cystoscopy, bladder biopsy and retrograde pyelograms were performed. Urinalyses (Figs. 3 and 4) while in the hospital revealed the typical ova of Schistosoma hematobium. The Hatch test (Fig. 5) proved their viability.

Telephone consult with the Center for Disease Control in Atlanta suggested the appropriate treatment which was given without delay to the patient. It is interesting to note that this patient had not been out of the United States for over two years.

Schistosomiasis is one of the most important parasitic infestations of man and affects greater than two hundred million people. Although the specific snail species necessary for the completion of the life cycle is not present in the United States, because of the development of many third world countries which involves dam construction and irrigation projects, workers at the site, whether local natives or personnel imported for the job, are at risk for infestation. Moreover, with the ease of international travel and the sociological trends of population changes, the appearance of schistosomiasis outside its endemic areas is on the upsurge. It is estimated that about 400,000 infected persons currently live in the continental United States and although there is no risk of transmission of the disease because of the inavailability of the snail host, the economic consequences as well as patient debilitation from this disease is staggering.

* Northside Urology Associates, 3646-F, Chamblee-Tucker Rd., NE, Atlanta, Ga. 30341.



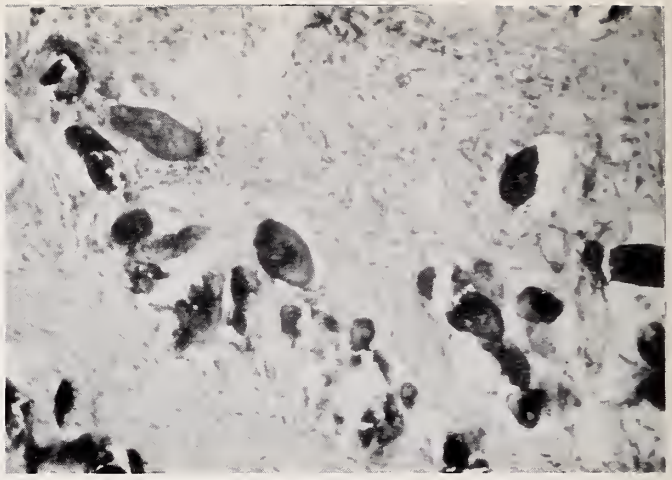








Fig. 1 (top left) — Plain film of abdomen showing extensive intramural calcification of bladder and left upper ureter. Fig. 2 (bottom left) — IVP revealing tortuosity and filling defects in left upper ureter. Fig. 3 (top right) — Bladder biopsy indicating extensive infiltration with Schistosomiasis ova. Fig. 4 (middle right) — High power view of terminal spine of S. mansoni ovum in urine. Fig. 5 (bottom right) — "Hatch" test of ova in urine revealing the live larva inside the ovum.

There are three species of schistosomiasis which infect man. S. mansoni is found in the Middle East, Africa, South America and the Carribbean. This parasite specifically resides in the inferior mesenteric veins of man, passes out of the body via the feces and microscopically is ellipitical with a lateral spine. S. japonicum is found mainly in Japan and China, infests the superior mesenteric vein, also passes out in the feces and is spheroidal with a small knob. S. hematobium is found in Africa and the

Middle East, and is mainly in the vesical veins in man. It infests the urinary tract, and microscopically is elliptical with a terminal spine.

Each ovum, after passing from man, requires a snail host to complete its life cycle wherein the parasites multiply enormously and subsequently are able to penetrate human skin after extrusion from the snail. After penetration, the specific schistosome migrates to its characteristic location in the human as mentioned previously. Copulation of the worms result in more eggs which are passed from man, into the snail and the cycle continues *ad infinitum*.

The characteristic final location of each specific schistosome will result in the typical pathology found. The enzymatic and antigenic secretions of the eggs induce a granulomatous reaction which results in the fibrosis and calcification seen in the liver, gut and urinary tract. Obstruction to portal blood flow is common, as is development of esophageal varices. Pulmonary hypertension may occur as well as focal brain lesions. Granulomas are frequently seen in the bladder and ureters.

The diagnosis is readily made by finding the ova in the feces and/or urine. Interestingly, it has been noted (as in my patient) that the hematobium eggs are usually not seen in the early morning urine but that maximum urinary output of eggs occur around midday. Bladder and rectal biopsy may also reveal the ova.

The therapy is not without risk. The Parasitic Drug Service of the CDC in Atlanta currently provides two drugs of choice. Niridazole (contraindicated in patients with CNS disorders or portasystem disease) and Stibocaptate. The interested reader is referred to the CDC for further information concerning these experimental drugs. The complications of the parasitic infection itself may necessitate other surgical intervention.

The diagnosis of schistosomiasis will not be made every day in one's office. Its occurrence, however, is more prevalent, and especially in a cosmopolitan area like Atlanta with its influx of peoples from all over the world, familiarity with some of the diseases most of us regarded as "only in the textbook" is becoming more necessary. Like all diagnoses, it is easy if one thinks of it — as Osler was often heard to say, "Listen to the patient; he is telling you the diagnosis."

Acknowledgement

The author wishes to thank Leonard L. Cotts, M.D. and David Stacey, M.D. for their guidance in the management of their patient.

Reference

Mahmoud, Adel: "Current concepts. Schistosomiasis"; *N. Eng. J. Med.* 297:1329-1331, 1977.

A Consumers Self-Test

MARVYN D. COHEN, M.D., *Columbus

THE PURPOSE OF THIS article is to discuss the cost of medical care of doctors by doctors. In a recent issue of *JAMA*, a letter from a Carlsbad, New Mexico, physician, prompted me to prepare this article.

Our patients and their families look on the high cost of medical care as a fact of life, but they think we physicians are not really aware of how much expense we create for them. This article is designed to test yourself. The list of 15 commonly ordered medical expenses and tests offer you the chance to see how informed you are.

Survey List	*My estimate of cost is:*
1. Semi-private hospital room	1. .....
2. CBC (routine)	2. .....
3. Urinalysis	3. .....
4. Serum bilirubin with fractionation	4. .....
5. Liver profile	5. .....
6. SGPT (isolated order)	6. .....
7. Complete spinal X-rays	7. .....
8. IVP	8. .....
9. Electrolytes (routine) N2, K, CL, CO_2	9. .....
10. Arterial blood gas determination	10. .....
11. Intensive Care Unit (day cost rate)	11. .....
12. IV Gentamycin dose (including supplies)	12. .....
13. Sigmoidoscopy (in office or hospital)	13. .....
14. Cardiac consult (in hospital)	14. .....
15. Gallbladder surgery (routine)	15. .....

There is another reason why this article is important. If you find yourself challenged by your nonmedical friends or if your patient asks you for an estimate of the cost of a procedure, etc., then even if it is not your specialty, you should be informed enough to express a realistic or reasonably accurate cost.

I was very dramatically corrected when a friend was sent to a cardiologist for a consultation. There was only a history, physical and EKG — no other tests. I guessed $35.00 cost. In reality, the bill was $50.00! Boy, here I am in pediatrics and I thought I was in a specialty!

After filling in your estimate costs, please turn to page 718 for the current average cost of the 15 items listed. There are many more commonly utilized procedures that we should have a cost-awareness of. This article is only a beginning to make us be aware of costs our patients are asking about.

* Chairman of MAG's Committee on Public Relations. Dr. Cohen's address is 1968 North Ave., Columbus 31901.

". . . if it's a fight that Mr. Carter wants—then it's a fight he'll get!"

Our Federation: Stronger than Ever

TOM E. NESBITT, M.D., *Nashville, Tennessee**

I BEGIN MY FORMAL remarks this evening by assuring you that I have given a great deal of time and thought to this, my first message as president of the American Medical Association.

I thought of the high honor that election to this office signifies, and I extend to you my sincere gratitude for that honor. I thought of the heavy responsibilities that the coming year will bring in this time of ordeal, and opportunity, for American medicine. And I extend to you my promise to do my utmost to help fulfill those responsibilities.

I also thought about, and summoned up the fortitude to *talk* about, what to my mind is *the* most imposing challenge for physicians today. I'm referring to the need for *individual physicians,* in their *own private practices,* to *voluntarily restrain the rate of professional fee increases.*

I'm well aware that historically, any discussion of the individual physician's right to determine professional fee levels has been all but forbidden ground for an officer of the AMA. Despite that fact, I'm going to make this request a focal point not only of this inaugural, but also a focal point of my message to America's physicians during the coming year. And while this message will be informal to the extent that it calls only for voluntary responses by individual physicians, there are some very compelling reasons why physicians should comply.

If certain proposals now in the Congress are enacted, for example, the *forbidden* ground of professional fees will become a *playground* for legislators, economists, health planners, consumerists and whomever. I refer, of course, to the legislative proposals which would impose arbitrary revenue restraints on hospitals, and perhaps extend such restraints to private practice, as some have proposed; if these proposals *are* enacted, then we can forget all the rhetoric about issues such as health planning guidelines and national health insurance. Because if government controls over hospital revenues and professional fees are added to *existing* controls arising from government's substantial health insurance financing commitments, then for all practical purposes, government will in fact *control* the quality, and the quantity (in terms of access) of the medical care system as a whole.

In short, the rationing of care, ala the British National Health Service, will be imposed on America. And while recent polls show that a majority of Americans favor national health *insurance,* they are against a national health *service* — financed through higher taxes and controlled by Washington.

To *preclude* such an eventuality, however, the private sector must provide effective *voluntary alternatives,* including cost control alternatives. And — as an officer of the AMA *and* a practicing physician — concern for the future of our profession prompts me to ask *individual physicians,* too, to demonstrate their sincerity by *restraining the rate of professional fee increases.*

Parenthetically, I believe that asking for such voluntary restraints by physicians is as *reasonable as it is pivotal.* It is reasonable because of the recent opinion polls which show that a majority of physicians, along with a majority of the general public, agree that the major health care concerns in our society today revolve around the cost issue. It is reasonable because I am not — I repeat, I am *not* — asking each physician in this country to suddenly make an across-the-board reduction in *specific* fees for *specific* professional services.

We physicians, after all, are not exempt from the hard realities of today's economy. We, too, are subject to higher overhead costs due to factors such as rising prices for heating fuel and medical supplies, employee wage increases and the general inflationary spiral; and these added costs necessitate periodic increases in our professional fees. What each of us *can* do, however, is place

(Continued on page 717)

* President of the American Medical Association and a urologist from Nashville, Tennessee. This is the text of Dr. Nesbitt's inauguration speech given at the 127th Annual Convention of the AMA, St. Louis, Missouri, June 21, 1978.



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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realistic restraints on the *rate* of these periodic escalations, realistic in terms of allowing us to cope with the effects of inflation while maintaining the quality of patient care.

This request is reasonable because it is asking no more of individual physicians than what we are asking of other components of the medical system. If we expect hospitals to reduce their rate of spending increases by two percentage points in each of the next two years, for example, then it is proper for us to demonstrate our own sincerity and good faith by moderating our fee escalation rates.

I should add that for most of us, the resulting financial difference itself would be moderate since it would be merely an extention of an *already existing downward trend* in the rate of professional fee increases. Evidence of this downward trend is provided by the Consumer Price Index (or CPI) of the U.S. Department of Labor, which reveals that the rate of increase in physician fees *has been declining since 1975.*

The CPI *does* show that during the year immediately following the end of federal price controls (between May of 1974 and May of 1975), physician fees increased *13.2* percent. But the "catching up" associated with the end of price controls has substantially moderated since then. During *1977,* for example, the rate of increase in physician fees was 9.2 percent, or *4* percentage points *less* than the rate for the 12-month period ending in May, 1975. For purposes of comparison, and using the same time frames, increases in the "all items" component of the CPI dropped from 9.5 to 6.8 percent.

In short, if each physician can moderate annual fee increase rates by just *one percent* in *each of the next two years,* our fee escalation rate would be close to the "all items" rate — perhaps even *under* it if recent all-items price increases continue. So by merely extending an existing trend, we can provide ourselves with a very visible — and extremely persuasive — argument in our struggle to preserve our pluralistic medical care system, which emphasizes *voluntary* problem-solving by the private sector.

The most formidable challenge by far facing American medicine in the coming months and years will be to deal forcefully with the cost problem which, in the final analysis, means forceful action by each physician. In that respect, my request for professional fee restraints may be *un*reasonable to the extent that many physicians simply don't know *how* to moderate the costs of medical practice — and hence their fees.

In this regard, there is a wide variety of possible approaches. For example, the AMA will sponsor *202* practice management workshops across the nation this year. Offering sound advice on improved efficiency and productivity in medical practice, it is estimated that increased office efficiency alone can reduce practice costs by as much as 5 percent.

Other possible answers have been suggested by the National Commission on the Cost of Medical Care. Certainly their recommendations already have been given considerable attention at this Annual Convention. Basically, the Commission stresses the importance of participation by individual physicians in local cost moderation efforts, many of which are applicable to the physician's office, as well as to the hospital.

Local peer review and utilization review programs are cases in point. Reasonable guidelines for medical care, based on necessity as well as quality, can help reduce costs. But only if individual physicians participate in, and abide by, the development and dissemination of these guidelines.

Of course, the *real* medical needs of patients must continue to receive the highest priority, whether in the hospital or in our offices. Nevertheless, rough guidelines for determining the necessity and appropriateness of medical care can serve as a rough yardstick for individual physicians in assessing patient needs before — and after — hospitalization.

Furthermore, *other* segments of our society (notably government and the public-at-large) have to be more responsible in *their* approaches to cost moderation — with the emphasis on "responsible." Certainly the Carter Administration's proposal to slap a flat, arbitrary limit on hospital revenues would be *ir*responsible.

By contrast, in my view the current Voluntary Effort *is responsible.* While on this subject, one cannot help but speculate as to the motivation, and hypocrisy, behind a recent decision by the Carter-Califano team. I'm referring to their specious decision to *call for voluntary restraints by industry* on the one hand, while attempting to *sabotage* our *own Voluntary Effort* on the other hand, by asking the Justice Department to *not* grant us an exemption from potential anti-trust action.

Apparently, some people in government are determined to ignore *the* irrefutable fact in medicine, namely that we can*not* provide high-quality care to patients for *less* than its basic cost. Meanwhile, our society must somehow persuade Americans that more healthful lifestyles can do more to reduce medical costs than all other efforts combined. We will take a step in that direction next month at the Joint Conference on Positive Health Strategies developed by the AMA and Senator Kennedy. It will be my privilege to join the Senator in co-chairing the Conference, which will be held July 25 through 27 in Washington, D.C.

The Conference itself, co-sponsored by 12 other national organizations broadly representative of our society, will *focus* on positive health strategies for schools, communities and the work place as well as possible health

"I'm referring to the need for individual physicians, in their own private practices, to voluntarily restrain the rate of professional fee increases."

action programs for the future. But, to me, the Conference also demonstrates that representatives of the private and the public sectors *can* put aside their differences and in mutual good faith seek practical solutions to real health care problems.

This is in stark contrast to the reprehensible attitude recently displayed by President Carter when he attacked the professions and private institutions, including lawyers, physicians and the AMA. In a letter of response, the AMA reminded Mr. Carter of this Association's manifold accomplishments in promoting good health and high-quality medical care for the American people. Our response also deplored the questionable logic of impugning the good faith of physicians at a time when mutual

action by the public and private sectors are so essential to the resolution of problems.

The White House also was struck by some well-placed editorial shots from the news media. The *Washington Post* took special aim at the President's seeming reluctance to "*let* doctors organize into the AMA." In a lead editorial the *Post* emphasized that, "The verb 'let' has an unwholesome connotation as though the right to organize could be extended or revoked as someone saw fit."

I believe the *Post*'s analysis might be extended by reminding Mr. Carter that America is built on democratic principles, with a small "d." Not the least of these principles is that strong, vigorous private associations serve as a check and a balance against the unreasonable growth of government and the unreasonable exercise of power and arrogance often attached thereto.

". . . it is estimated that increased office efficiency alone can reduce practice costs by as much as 5 percent."

Therefore, it seems to me that rather than make gratuitous attacks on private sector professions and institutions, the President would be better advised to devote his energies to more constructive pursuits — including the thus-far futile pursuit of his own campaign promises.

But if it's a fight that Mr. Carter wants — then it's a fight he'll get!

Because we physicians are well advised to continue our struggle to avoid the pitfalls inherent in governmentalized medicine. For example, during recent AMA-sponsored trips to study health care systems in Europe and the Far East, these pitfalls truly became apparent.

Any government-enacted and government-dominated health care insurance program inevitably results in significant reductions in the quality — and ultimately the quantity — of medical services available to patients. And this reduction may have several manifestations, such as cutbacks in research, detrimental changes in the curricula and length of training of physicians, and diminished quality in terms of a nonavailability of the modern medical technology that Americans have come to take for granted. The upshot of all this would be a reduction — or rationing — in the *quantity* of medical services available to patients.

This is evident in Great Britain; it is dramatically illustrated in the People's Republic of China; and it is currently being confronted as a crucial issue by the Medical Associations of Japan and Australia. And, of course, it has obvious implications for the "Great Health Care Debate" here in our own country. In all areas, not just in medicine, our society — like other societies — is facing the difficult task of seeking an accommodation between the virtually unlimited wants and needs of individual citizens, and the limited resources — financial and otherwise — available to fulfill those wants and meet those needs.

It should be obvious that every physician shares in the responsibility to help our society make the *right* choices.

Both as individual practitioners, and as a profession made strong through this medical federation of ours, we must help fashion practical, effective answers to problems, with no little emphasis on voluntary answers to cost problems.

I say all this knowing full well that we can be discouraged by the difficulty of reaching a consensus on the right choices even among ourselves, much less a consensus with other segments of our society, including government. The adoption of new policies, after all, often creates disagreement both within and without the profession, as the delegates at this Annual Meeting can attest.

We can also be discouraged by those critics who insist that this Association is a doddering, debilitated relic of the past. Well, I have a couple of appropriate, closing quotations which offer large measures of reassurance. The first one pointed out:

> "Doubtless each member of the House has an opinion . . . on each of the various issues which may be considered at this Session of the House. It is reasonable to expect these opinions to conflict to some extent when we think of the wide variations in the local problems (of) various communities throughout the country."

That statement was made *40* years ago by Dr. Harrison Shoulders, who was then Speaker of the House, and who subsequently preceded me as an AMA President from Nashville, Tennessee.

The second quotation goes like this:

> "It is no secret that there has been an attempt in various places to lead the American people to believe that the (AMA) is not representative of the American medical profession, that it is a weakened, disrupted, failing organization."

And yes, *that* statement, too, is 40 years old, made in 1938 by Dr. Irvin Abell, then President of the AMA.

For *decades*, then, critics have been greatly exaggerating the death of the AMA; and the *reason* they do so is that to impose their *own* social views on the public, they must first seek to discredit their *strongest* rivals. And this federation of ours is much stronger in 1978 than it was in 1938.

It is stronger in its support for continued rivalry between the public and the private sectors, which is healthy for democracy as a whole.

It is stronger in terms of its pragmatic policies, programs and proposals to deal with contemporary health care problems.

It is stronger as both protector and promoter of American medicine's superb, healing quality in medical education and practice.

And it's squarely up to you, and me, and every physician in this country worth the name to keep it that way!

You have my unqualified pledge to disseminate these truths during the coming year.

Answers to consumers self-test on page 713.

(Current average costs in the Columbus, Georgia, area)

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"Organized medicine needs to organize and manage the health industry in an efficient, effective and less expensive manner. . . . It should firmly seize the opportunity to act in an enlightened manner before it is too late."

Prepaid Health Insurance: Menace or Messiah for Organized Medicine?

F. WILLIAM DOWDA, M.D., *Atlanta**

FIRST, LET US EXAMINE the facts of the economy of the purchase of medical care.

Fact one: The purchase of medical care is currently costing the American patient an arm and a leg.

Fact two: The American doctor is getting less of the health care dollar than ever before.

Fact three: The latest Harris poll shows only 29% of the American public believes the solution to their medical economic dilemma lies with federal bureaucracy and national health insurance.

Fact four: The same poll shows that the American public does want *relief* from the high cost of medical bills.

Fact five: American business, currently paying at least one-third of the nation's medical bills, also wants financial relief.

To whom can these folks turn? Logically, they have two choices — the American doctor, who controls most of the medical care expenditure, or the federal government. Insurance against medical bills has already proved not to be the answer. Apparently, both the American patient and American business are holding their breath to see what organized medicine will do — recognizing the only true financial relief lies within organized medicine.

Quo vadis: The answer has been clear for several years. Organized medicine needs to organize and manage the health industry in an efficient, effective and less expensive manner. The Foundation movement of San Joaquin, California, is a classical example of this approach, with the promulgation of good quality medical care that is appropriate to the patient's complaints and diagnoses. While the AMA has lagged behind in recognizing the value of this approach, the federal government has been quick to seize upon it, changing its name and birthing the HMO and IPA.

An HMO is purely and simply a prepaid health plan in which a board of directors, hopefully controlled by doctors, would offer a package of service to the patient for a set price per year. There is nothing sinister or evil about the approach, as the main economy of effectively operating HMOs lies in concurrent hospital review with reduction of patient days in the hospital per 1,000 plan members.

I see nothing wrong with putting less money in the hospital coffers and more in the doctor's pockets. The IPAs are organized to insure that just that sort of thing will happen. An IPA is simply an organization of M.D.s open to all M.D.s in the area rather than closed panel, designed to protect the rights, privileges and income of the doctors. What will happen if we don't do this? Look at Winston-Salem, N.C., and the R. J. Reynolds Co., where this financially enlightened company has organized its own HMO-type activity with great success both for itself and its employees.

Rising cost and inflation pose a problem for medicine; however, with every problem there is afforded an opportunity, and I feel organized medicine should firmly seize the opportunity to act in an enlightened manner before it is *too late*. Prepaid health care is here. We cannot go back to the 19th century, but then who would want to do so and be without penicillin and the other advances of the 20th century? Prepaid health care offers medicine a cure for many of its ails just as penicillin has affected a cure for many ailing Americans.

* MAG delegate to the AMA. Dr. Dowda's address is 490 Peachtree St., NE, Atlanta, Ga. 30308.

Recent Changes in Workers' Compensation Laws

The 1977 and 1978 sessions of the General Assembly have passed extensive amendments to the Georgia Workers' Compensation law. Many of these changes are of particular interest to the medical profession.

In 1977, the General Assembly passed legislation which created a Subsequent Injury Trust Fund. Georgia thus became the 50th state to establish such a fund. The main purpose of the legislation was to encourage employers to hire the handicapped. Whenever a pre-existing permanent impairment combines with a subsequent injury to produce total disability, the employer or insurer has a right to reimbursement from the fund for a part of the benefits due as a result of the subsequent injury. The legislation sets out the pre-existing conditions which may combine with an injury to establish a right to reimbursement and sets forth the amount of reimbursement which an employer or insurer is entitled to receive. The medical questions which will arise under this legislation will involve whether and to what extent disability from an injury was increased by the combination of the injury with a pre-existing condition, or whether such a combination of events accelerated death. It is anticipated that the existence of the fund will reduce litigation and thus speed up payment of income benefits and medical expenses.

The 1978 legislation, effective July 1, changed everything from the method of payment of benefits to the name of the board, from State Board of Workmen's Compensation to Workers' Compensation. Benefits for total and temporary partial disability are increased. The most wide-ranging change is the institution of the direct payment system, under which payment of benefits is started without the necessity of Board approval of an agreement. It is hoped that this system will speed up payment of income benefits and medical expenses to those entitled to receive them.

One change in the workers' compensation law which should be of great interest to the medical profession is a new treatment of permanent partial disability. The 1978 amendment eliminates the previous provision for a specified healing period and makes its provisions applicable whenever a disability becomes partial in character but permanent in quality. In practice, this terminology means the same thing as reaching maximum improvement.

There is one other major change in this portion of the workers' compensation law. For the first time in Georgia, there is a provision for benefits for partial loss of use of the back as a whole. In practice this will usually mean that the back is treated as a specific member, i.e., the same as an arm, leg, hand, foot, etc. This provision is not limited to the back, however. The intent of this provision is to give some incentive to employees to return to work by allowing them to be compensated for loss of function, even if they do return to work. This provision is a completely new one and may, unfortunately, spawn litigation, but it is believed that this problem should resolve itself rather quickly and that thereafter the system for dealing with back injury and other body-as-a-whole claims should run more smoothly.

Another change directly affecting the medical profession is a new method of choosing a treating physician for an injured worker. Every employer is now required to post in a prominent place on its premises a list of at least three physicians, professional associations, professional corporations, or persons licensed to practice the healing arts. This last authorized group was added by legislative amendment but does not affect the medical profession unless an employer chooses to put such a person on the list, which is to be known as the panel of physicians. The employer has complete freedom in choosing panel members. The employer will assist the employee in choosing a panel member to treat him. The employee is permitted to change from one panel member to another once without order of the board. Any subsequent changes will require such an order. Failure to maintain and assist employers to use a panel of physicians will allow the employee to seek treatment from a physician of his choice at employer's expense.

The provisions governing the direct payment system, filing of claims with the Board, and hearings before administrative law judges should not affect the day-to-day practice of the medical profession. It should be noted that many Board forms will be changed or eliminated; however, the medical forms are not among these.

The final change which is of interest to the medical profession is one which makes entitlement to fees contingent on filing of forms required by the Board. This provision is not new but merely codifies what has been previously implied from a Board rule. The filing requirement is met by filing the forms with the employer or the insurer.

Any physician may obtain further information by calling the Board, (404) 656-2900. The Board will also provide speakers.

Lee Southwell
Staff Attorney
Workers' Compensation

A case of group B streptococcal peritonitis in a child with nephrotic syndrome is presented. A review of pediatric medical records at two Atlanta hospitals for the years 1971 and 1976 indicated that most cases of peritonitis in nephrotics were due to pneumococcal infection.

Group B Streptococcal Peritonitis in a Child With the Nephrotic Syndrome

PHILLIP H. KALEIDA, M.D., and STUART E. STARR, M.D., *Atlanta

INFECTION, IN GENERAL, and primary peritonitis, in particular, are well-recognized complications of the nephrotic syndrome.[1] Organisms previously reported as causing peritonitis in nephrotics include pneumococcus, enterococcus, other streptococci (grouping and typing not specified), Hemophilus influenzae, E. coli, pseudomonas and Citrobacter.[2-4] A case involving a previously unreported etiological organism prompted the present report.

A 4 7/12-year-old black male was admitted to Grady Memorial Hospital on 7/15/75 with the diagnosis of nephrotic syndrome in relapse. The patient was diagnosed as having idiopathic nephrotic syndrome when he was 1 1/2 years old. This was later confirmed by renal biopsy. This child is of particular interest in that he had documented episodes of pneumococcal sepsis and peritonitis in both 1972 and 1973 and E. coli sepsis and peritonitis in 1974. Over a three-week period prior to admission, the patient developed abdominal swelling and periobital edema and gained 6.4 kg in weight. He complained of abdominal pain and developed vomiting and watery brown stools one day prior to admission. On the day of admission, he developed shortness of breath and felt warm to palpation. The only medication that he was receiving was Prednisone, 40 mg every other day.

Physical examination revealed a temperature of 38.3°C, pulse 118, respiratory rate 46, blood pressure 114/58, weight 29.0 kg. The patient was moderately Cushingoid in appearance and was in mild respiratory distress. The abdomen was markedly distended, although initially nontender, and there were no audible bowel sounds. There was 3+ pedal and 2+ pretibial edema. Physical exam was otherwise unremarkable.

Initial laboratory data included: Hct 36.9, Wbc 15,500, 16 bands, 74 segs, 9 lymphs, 1 mono, adequate platelets; BUN 20 mg%, Na 135 mEq/l, K. 4.0 mEq/l, Cl 105 mEq/l, HCO_3 23 mEq/l, glucose 66 mg%, cholesterol 427 mg%, bilirubin 0.3 mg% total, 0.1 mg% direct, SGOT 16 IU. Urinalysis revealed pH 5.0, protein 3+, no sugar, acetone, blood or cells. Serum protein electrophoresis: albumin 0.6 gm%, alpha-10.1 gm%, alpha-2 1.7 gm%, beta 0.8 gm%, gamma 0.3 gm%, total 3.5 gm%. Serum immunoglobulin determination on 7/29/75: IgG of 390 mg%, IgM 220 mg%, and IgA 147 mg%. An X ray of the chest was negative except for poor inspiratory effort secondary to abdominal distention. A KUB confirmed massive ascites.

Clinical Course

Cultures obtained on admission of the blood, urine and stool were subsequently negative. A throat culture grew "beta strep, not group A by disc method." Because of unexplained fever and the history of previous episodes of peritonitis, paracentesis was performed: 20 cc of cloudy, blood-tinged ascitic fluid was obtained. Examination of the fluid revealed 27,740 wbc's (99 segs, 1% lymphs), 11,730 rbc's, sugar 50 mg%, protein 0.4 gm%; a gram stain showed gram positive diplococci in chains. Multiple cultures of the ascitic fluid yielded a Beta hemolytic streptococcus. This organism was not inhibited by bacitracin, failed to grow on bile-esculin medium, and hydrolized sodium hippurate and was therefore presumptively identified as a group B streptococcus.[5]

The patient was initially treated with ampicillin

* Department of Pediatrics, Emory University School of Medicine. Dr. Kaeida's current address is Pediatric Clinic, 1109 Burleyson Dr., Suite E, Dalton, Ga. 30720. Dr. Starr is currently at the Children's Hospital of Philadelphia, Pa.

200 mg/kg/day and gentamicin 5 mg/kg/day both given intravenously. Three days later when the organism was identified as a streptococcus sensitive to penicillin, the patient was switched to aqueous penicillin G 200,000 units/kg/day intravenously for seven days. The patient made an uneventful recovery.

Medical Record Review

The records of children with nephrotic syndrome and peritonitis were reviewed for the years 1971 to 1976 (inclusive) at the Grady Memorial Hospital and the Henrietta Egleston Hospital for Children in Atlanta, Georgia. Only those cases documented by positive peritoneal fluid cultures or positive blood cultures in the face of peritoneal signs were evaluated.

There were 11 documented episodes of peritonitis in seven children at the two hospitals. The patients consisted of four males and three females, with ages ranging from 18 months to 18½ years at the time of infection. Two were white and five were black. Four children were diagnosed as having lipoid nephrosis or minimal change disease. One child had nephrosis secondary to systemic lupus erythematosus with focal proliferative glomerulonephritis, and two had nephrosis secondary to chronic glomerulonephritis. The organisms responsible for peritonitis in these patients are shown in the table. Each child had at least one episode of pneumococcal peritonitis. There was one episode each of peritonitis to E. coli, Hemophilus influenzae, and group B streptococcus.

ORGANISMS ASSOCIATED WITH PERITONITIS IN CHILDREN WITH NEPHROSIS (1971-6)

Organism	Number of Episodes
Pneumococcus	8
Group B Strep	1
E. coli	1
H. influenza	1

Discussion

The pneumococcus appears to be the predominant organism causing peritonitis in infants and children with the nephrotic syndrome as noted in this study and reported by others.[3, 4]

To our knowledge, the group B streptococcus has not previously been noted to be a pathogen in this clinical setting. While the incidence of neonatal group B streptococcal infections has risen in recent years, interestingly peritonitis has not been noted as a manifestation.[6]

The present case and a recent report of primary peritonitis due to group G streptococcus[7] illustrate the importance of fully identifying streptococci isolated from body fluids. While biochemical tests may be used for presumptive diagnosis, as was done in this case, ideally precipitin typing should be obtained, particularly for organisms that appear not to be group A or group D streptococci.

Acknowledgement

We thank Dr. Richard E. Blumberg for his encouragement and critical review of the manuscript.

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Private Enterprise at Work

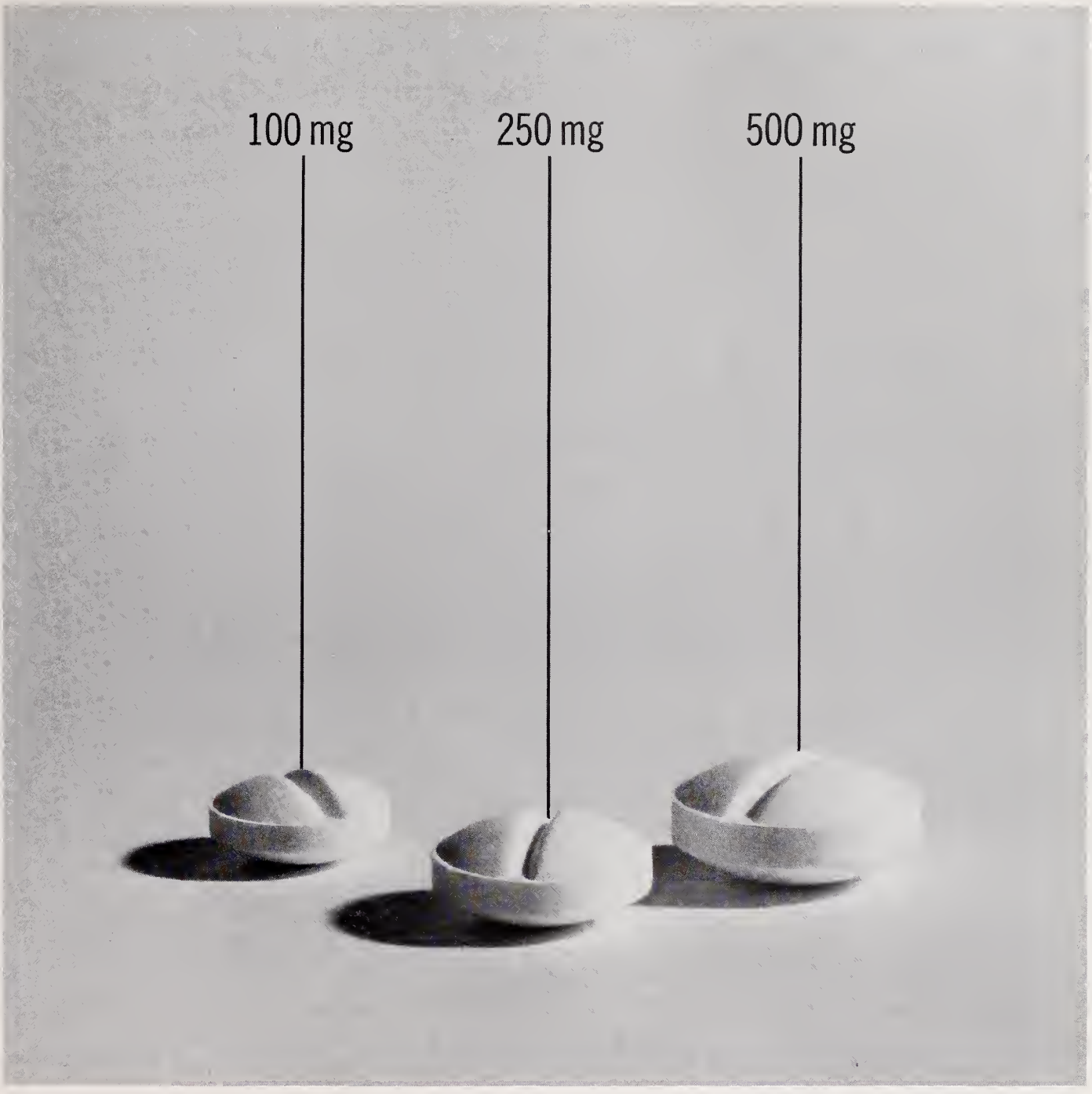
(Editor's note: Here is a prime example of how private enterprise can – and does – step in where government fails.)

American Medical International (AMI) gave Los Angeles school officials $48,000 to keep alive nursing classes scheduled to be eliminated by Proposition 13-related budget cuts.

School officials said funds for licensed vocational nurse (LVN) training were to end June 30.

AMI president Royce Diener said company executives were made aware of the program's cancellation by a nursing student's letter to the *Times* published June 25. Diener said AMI is providing the funds because "AMI is in the hospital and health care field and we recognize the value of the LVN program. Also, this reflects our philosophy about Proposition 13, which we see as the public's expression against unnecessary bureaucracy and costly regulations, not a device to strike down essential and worthwhile services.

"Business is in a position to make decisions quickly so that valuable programs facing cancellation can be saved," Diener said. "I am sure this will not be the only example of a company stepping in with support."



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MAGNET '78

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Dear MAG Member:

Read this and if you miss it, you deserve it.

Practice Productivity, Inc. (PPI) of Atlanta will join us again this year to cover two timely topics.

On the first day, PPI president, Bill McGrath, and PPI workshop instructor, Walt Disher, will examine one of our greatest concerns today - cost containment. More specifically, Bill and Walt will attack the mutually shared problem of "FIGHTING INFLATION WHILE MAINTAINING QUALITY CARE." Costs can be controlled scientifically; however, an overview of the impact of inflation and a look at the necessary expenses precede his answer on how to do something about it.

A scrutinizing eye will be turned toward reducing collection costs while enhancing patient relationships. How? Practice Productivity spells it C-O-N-S-I-S-T-E-N-C-Y. The rewards of new collection techniques should spell S-U-C-C-E-S-S for us all. And the legal impact of the "Truth-In-Lending" laws concern one and all - whether we like it or not.

Indeed, insurance can be a nightmare for good collections - and for patients. Getting rid of paperwork may just go hand in hand with automating. PPI will look at these aspects of fighting inflation and more.

On the second day, Greg Gates, a PPI workshop instructor who is also a member of the State Bar of Georgia, deals with our inevitable, perhaps latent, concern: "WHAT TO DO WHEN THE DOCTOR DIES."

Greg's forthright inspection will encompass estates, wills, trusts, insurance and probate. The entire matter of selling the practice, handling patient records, and being an executor will be valuable and direct in approach. All too often, a physician leaves without giving his loved ones the necessary advice and tools to deal with the world ahead.

This is the outline for the MAGNET program 1978. We have designed this for you and your loved ones. This program invites you, your wife and your practice's key employees to participate in an exciting and educational conference.

In previous years, our turnouts have been satisfactory, but this year's should be a big one. For goodness sakes, take advantage of the best thing MAG offers!

Plan to attend.

Sincerely yours,

Marvyn D Cohen, M.D.

Marvyn D. Cohen, M.D.
Chairman, Committee on Public Relations



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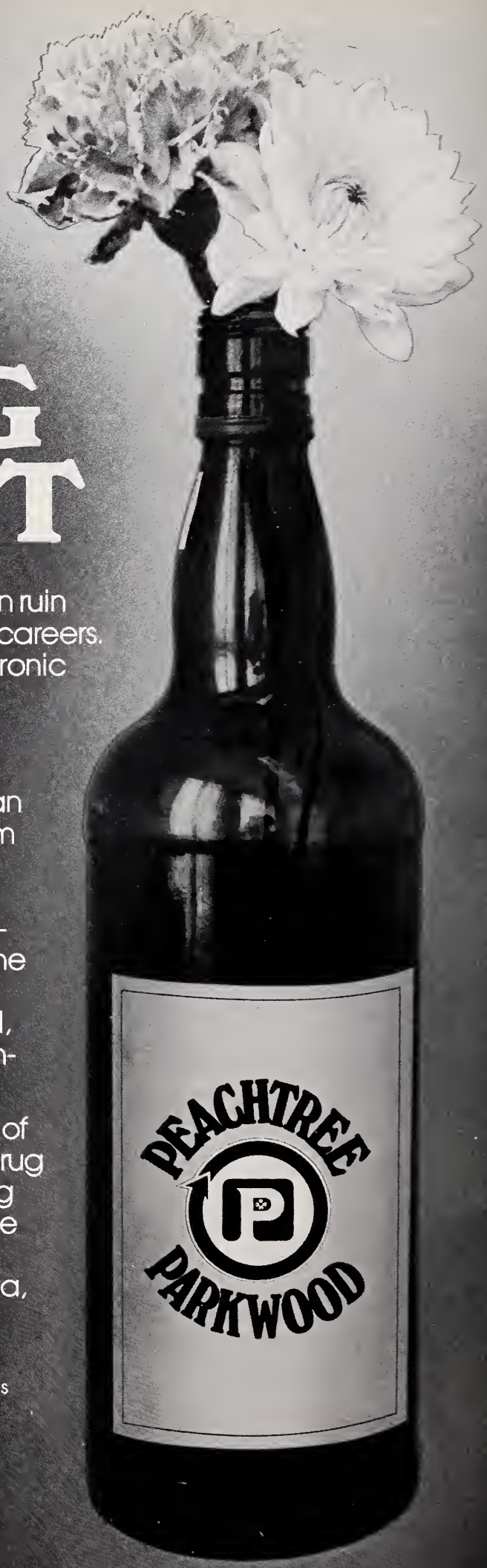
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Complete information on the services of Peachtree and Parkwood's Alcohol and Drug Addiction Unit may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

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editorials
editorials

An Innovation in Rural Health Care: The Second Physician Recruitment and Pre-Practice Seminar

RURAL AREAS ARE AMONG the most medically underserved segments of our country and the magnitude of the problem is well known to most physicians. Despite the recognized need, solutions to the problem of medical manpower shortages have not been forthcoming, nor have there been a large number of innovative ideas. The central issue is one of numerous small communities in need of reliable, quality, continuing medical care. Many of these communities lack the indigenous resources to attract and retain such physicians and medical care.

The overall problem of medical manpower shortage is complicated by the unexploited potential of resident physicians who are completing their training, principally in the primary care areas, and who might be interested in practicing in such non-urban settings. These new physicians generally have little knowledge of the peculiar demands that might be placed on them by a non-urban practice, nor do they have a good concept of the advantages of the lifestyle in this setting.

With these different problem areas in mind, the first Pre-Practice Seminar and Physician Recruitment Conference was held at Callaway Gardens in October 1977, jointly sponsored by the Medical Association of Georgia and the Southeastern Institute for Community Health, Inc., LaGrange, Georgia. This three-day meeting provided a one-day session for communities directed at the issue of physician recruitment. At the end of the first day, the physicians and their spouses arrived and these same communities were then given two additional days during which they had an opportunity to recruit the resident physicians attending the conference. The physicians themselves, during the last two days of the conference, attended sessions designed to give them an overview of the advantages and problems that are related to non-urban practice. During these two days, the resident physicians also had an opportunity to meet with communities which they felt might be potential practice sites. Thus, a job market for these physicians was created and non-urban communities were given a chance to "sell their wares."

The physician's program was directed toward three specific problem areas thought to be unique to non-urban practice: (a) Meeting the demand; (b) Quality of life, and (c) Quality of care. The first problem, meeting the high demand for patient care, was addressed by presentations offering alternative ways of meeting the demand, including better use of nursing personnel, use of para-medical personnel such as physician assistants, and innovative methods of adding physician manpower. The problem of quality of life was addressed in terms of lifestyles, availability of local medical resources and facilities, and variations in practice arrangements. The problem of quality of care was dealt with in terms of continuing education, medical records management, and contending with governmental agencies. Panelists were principally practicing physicians or those dealing with the immediate practice world.

The initial conference was well attended by forty-one physicians and their spouses

and forty-five communities or hospitals from Georgia and Alabama. Evaluation of completed questionnaires from both the attending physicians and communities generally indicated a very favorable response to the program format in terms of information and opportunities for both groups.

A second Pre-Practice Seminar and Physician Recruitment Conference will be held at Callaway Gardens September 29-October 1, 1978, jointly sponsored by the Medical Association of Georgia and the Southeastern Institute for Community Health, Inc. Communities and physicians in non-urban areas are encouraged to attend and participate in the recruitment activities. If the conference continues to be well attended by both residents and communities, it will become a planned annual activity of the two sponsoring organizations.

Several interesting questions were raised by the initial conference. The first relates to the question: Toward which level resident should this kind of conference be directed? It was initially our impression that third-year residents who would be going into practice in July of the following year would be the most suitable candidates. It has become apparent after one year's experience, however, that many decisions as to specific practice sites have already been made by time the resident enters his third year and thus this conference might be more useful for second-year residents. The second question: Will earlier exposure to a non-urban practice setting make medical students and residents more interested in the lifestyle advantages of non-urban areas? The third question related to the communities: Do other avenues exist to provide rural communities with the information and the proper tools for recruitment and retention of physicians?

During this second annual Conference, the interests and needs of communities and young physicians will come together during the weekend of September 29-October 1, in a fashion unduplicated elsewhere in the country. It is a unique setting and one which will be watched with interest in terms of the bottom line — actual placement of physicians with rural communities.

M. Julian Duttera, M.D.
Chairman, MAG Access to Health Care Committee
President, Southeastern Institute for Community Health, Inc.

Don't Miss MAGNET '78

"IF YOU MISS THIS conference, you deserve it."

This "Madison-Avenue-like phrase" has been displayed in our *Journal* and in mailouts to our membership for the upcoming MAGNET Conference to be held at the Terrace Garden Inn on the weekend of October 24-25. The program was set up by the MAG Committee on Public Relations and Practice Productivity, Inc. This Atlanta management group provides valuable information necessary for all of us in practice.

The Sunday morning program in particular has been devoted to an unexpected and unwanted event: When we are no longer able to practice, either by death or infirmity, what do we do? What do our families do? What arrangements should and can be made in advance?

You should make that extra effort to attend. You should *bring your wife* to let her know what to do if and when difficult times arise.

Some of you say MAG does nothing for you. Well, I say it is because you do not avail yourself of services offered. This MAGNET weekend is one that could help you in your practice and also help your loved ones.

I have been actively involved in MAG for the last four to five years and I find it rewarding — hopefully helping my cause and that of my fellow doctors. The MAGNET Conference has been one of the true benefits of membership. So in closing I will say once again, if you miss this Conference, you deserve what you get!

Marvyn D. Cohen, M.D.
Chairman, MAG Committee on Public Relations

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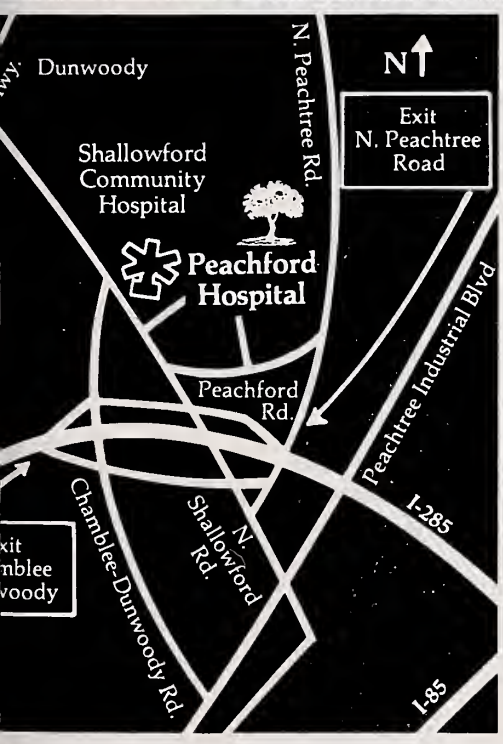
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president's letter



Time Out

THE PRACTICE OF MEDICINE nowadays is often fraught with many vexations, trials and tribulations. Over the years, I have often sought refuge in the haven of a poem, framed and hanging on my wall next to my desk. It has never failed to soothe my tensions and apprehensions and restore my sense of values. Written by Holbrook, the poem goes something like this:

"Slow me down, Lord! Ease the pounding of my heart by the quieting of my mind. Steady my hurried pace with a vision of the eternal reach of time. Give me, amidst the confusion of my day, the calmness of the everlasting hills. Break the tensions of my nerves and muscles with the soothing music of the singing streams that live in my memory.

"Help me to know the magical restoring power of sleep. Teach me the art of taking minute vacations . . . slowing down to look at a flower, to chat with a friend, to pat a dog, to read a few lines from a good book.

"Remind me each day of the fable of the hare and the tortoise that I may know that the race is not always to the swift; that there is more to life than measuring its speed. Let me look upward into the branches of the towering oak and know that it grew great and strong because it grew slowly and well.

"Slow me down, Lord, and inspire me to send my roots deep into the soil of life's enduring values, that I may grow towards the stars of my enduring destiny."

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

1978-79 ROSTER

One free copy of the 1978 Roster will be mailed to each active member of the Medical Association with the August 1978 issue of the **Journal.**

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available to members by advanced order for $5 a copy; non-members will be charged $15 per copy.

Checks should be made payable to the Medical Association of Georgia. Copies that have been ordered in advance will be mailed out at the end of August.

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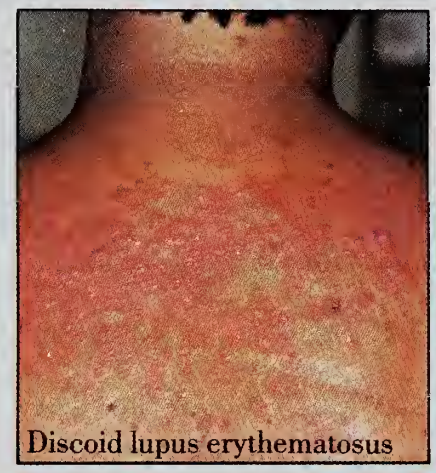
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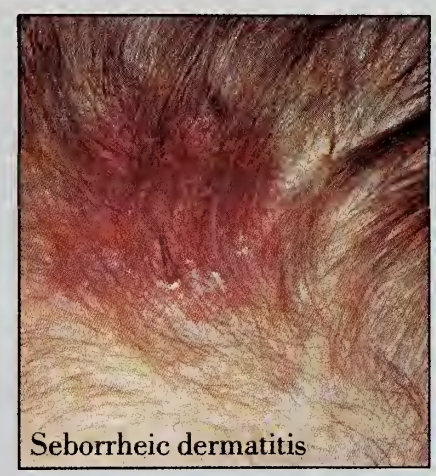
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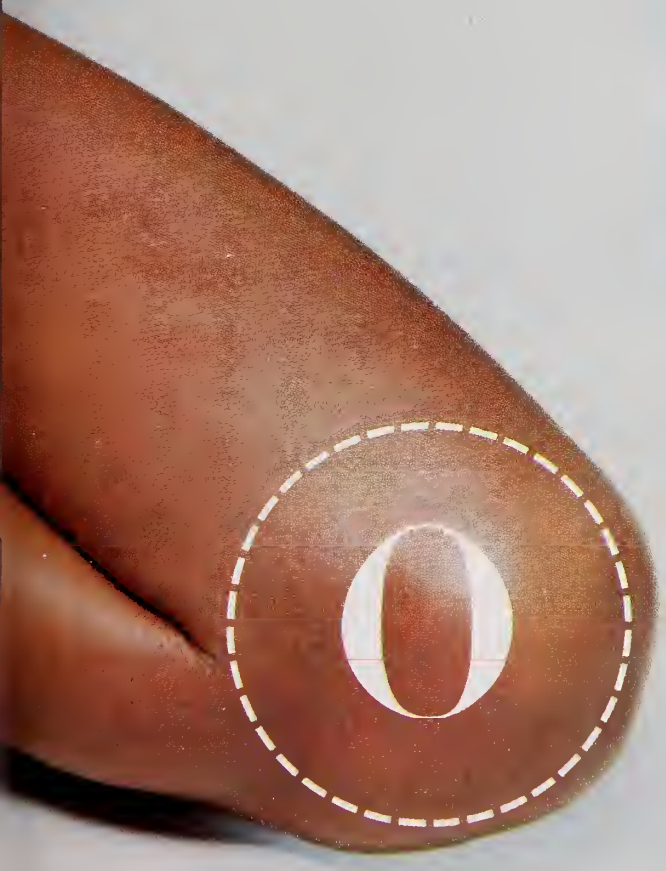

After 10 days

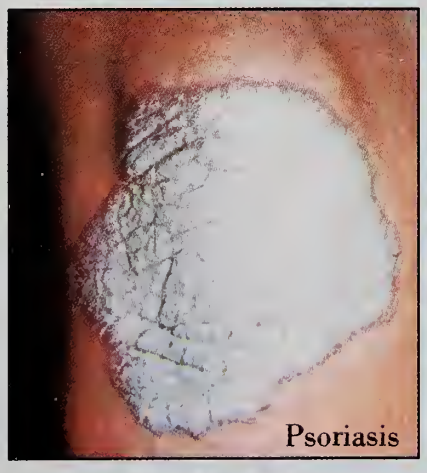
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Case histories on file at Squibb Institute for Medical Research

See next page for brief summary

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CONTRAINDICATION: Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

PRECAUTIONS:
General—If irritation develops, discontinue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.
Usage in Pregnancy—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.
Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. Keep the patient under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Discontinue use of the occlusive dressing if elevation of the body temperature occurs.



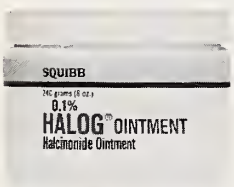
Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

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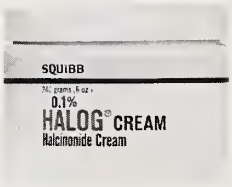


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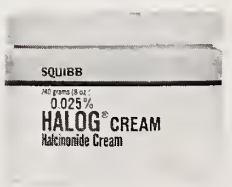


240 g

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I've told this before . . .

(Editor's note: To some, chipmunks may be adorable little creatures, but to the man in Dr. McDaniel's story, they represent nightmarish memories. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Chipmunks in Maine

ONE BEAUTIFUL SPRING afternoon recently, a couple dropped by our home to discuss the details of a little trip that we were planning. The weather was so pleasant that we elected to sit outside and watch the birds that were feeding on the berries of a nearby mulberry tree. It was also fascinating to watch the antics of the chipmunks as they performed all sorts of acrobatics to pluck a juicy mulberry.

"Chipmunks are cute little varmints," I remarked, "but they certainly are a nuisance and quite destructive to the vegetables in my garden and to Marguerite's flower bulbs . . . ," and I went on talking about traps, cats, repellants, etc., but to no avail.

My friend Bob listened to my dissertation with gentlemanly attention and then said that he disliked the little high-tailed rodents for all the reasons that I had indicated but his aversion for them became a hatred in 1942 . . . and when I gave him a quizzical look . . . he took a long sip of his drink and went on to say:

"Soon after Ann and I were married, I bought out a little business that I had been trying to get for a long time. It was located in northern Maine near the coast. We rented a typical small one-and-one-half story house on the Waites Landing Peninsular. On this peninsular lived 14 families; there was one road leading into it and all the mail boxes were placed on the turn-around at the end of the road. This was a gathering place when the mail came and likewise a news broadcasting station for the community. "In this section of Maine," said Bob, "people were by and large hard workers, God-fearing and lived within their means. There were four times a year that they really let their hair down and had a holiday, namely Christmas, New Year, 4th of July and Labor Day.

"As was the custom, someone announced at the mail boxes that the Labor Day celebration would be at their home Sunday night . . . a B.Y.O.B. affair."

Now Bob and Ann were both graduates of fine, old Southern schools and had attended many festive occasions, but Bob said that he woke the next morning about 10 o'clock with a hang-over that was the acme of all hang-overs. He said that he actually thought that he was not long for this world. When he finally managed to stabilize himself, he crept cautiously downstairs to brew some coffee, and as he approached the foot, he glanced over at the telephone on the table and thought that he saw it move. He looked around the room, but the bright light from the door hurt his eyes. Then he ever so slowly looked back at the telephone and focused his eyes. This time he knew damned well that the hand piece moved.

Was his adled mind playing dirty tricks on him? — A terrifying situation!

Bob crossed himself, held up his right hand and promised to the good Lord, the Virgin Mary and to any others that might be in authority, that if he could just get over the predicament he was in, he would never touch a drop of John Barleycorn again.

After taking these oaths, he let his eyes wander back to the telephone again. This time he saw a chipmunk jump off the receiver and scamper off across the floor.

He knew that he would have to tell this story, but he knew also that he would have to catch the chipmunk to make even his wife believe it. He closed all the doors, went into the kitchen and the only thing that he could find was a deep casserole dish. He figured that if he could put the dish over the chipmunk, it would at least prove that he did not have the DT's.

Down on his hands and knees he went, with the casserole poised in his right hand. He hemmed up the little varmint in a corner, slammed down the casserole, but missed him. Then to another corner and missed him and missed him again.

In the meantime, Miss Ann heard all this slamming and banging going on downstairs. She hopped out of bed, not even putting on shoes or robe, and hit the top of the stairs, only to hear her ever-loving husband jabbering and see him crawling around on his hands and knees, with a casserole dish in his hand, striking it vehemently on the floor at intervals.

Wife-like, she conjured up all sorts of terrible things and was tremblingly dialing the emergency ambulance service when Bob announced triumphantly, "I've got him!"

"Got what?" sobbed Ann.

"A chipmunk," he answered. "Thank the Lord."

Now Bob wonders to this good day if anyone would have ever believed his story had he not captured that chipmunk, and that's why he thinks they are treacherous little animals and dislikes them so intensely.

J. G. McDaniel, M.D.
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How I Do a Pap Smear

ERNEST W. FRANKLIN III, M.D., *Atlanta**

Objectives

CYTOLOGIC SCREENING of the female genital tract seeks to identify the population suspected of having pre-invasive or invasive neoplasia. It identifies the population at risk as a screening technique and should *not* be given the diagnostic credibility of a biopsy. The Pap smear optimally obtained, properly screened and interpreted and clearly reported may, indeed, provide the clinician with a clear indicator of the presence of neoplasia. More commonly, however, the Pap smear is subject to a high degree of false positives and false negatives. In a screening technique to identify the population at risk, the false negative rate is of greater concern and is significant, approaching 40% for a single cytologic determination arises as reported in several series.

CERVICAL MALIGNANCY — Invasive cancer of the cervix arises predominately out of cervical intraepithelial neoplasia (CIN), formerly designated carcinoma in situ or dysplasia. The accuracy of the Pap smear in detecting both invasive and pre-invasive cancer can be excellent but all too frequently is suboptimal. These lesions arise at the transformation zone, the dynamic interface at which squamocolumnar epithelium meet and in which squamous metaplasia takes place. This area is located in the region of the anatomic external os of the cervix but may recede up into the cervical canal with advancing age. Optimal cytologic detection, therefore, involves obtaining specimens from the area of the external os and cervical canal. Accuracy of a single Pap smear will vary from 40 to 80 percent depending on adequacy of collection, preservation and interpretation of the smear. A second and third cytologic screening at subsequent intervals should increase the accuracy of detection to 85 to 95 percent, but still not 100 percent. Also, the Pap smear may reflect only the presence of an abnormality. It is not necessarily a diagnostic tool defining the severity of the abnormality, i.e., preinvasive vs.

* Member, Board of Directors, American Cancer Society, Georgia Division, Inc. Gynecologic Oncologist, Suite 100, 5669 Peachtree Dunwoody Road, N.E., Atlanta, Ga. 30342. Prepared at the request of the American Cancer Society, Georgia Division. Others wishing to contribute papers to this department are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

invasive cancer. Also, the significance of one positive cytology is *not* negated by subsequent negative cytology.

ENDOMETRIAL CARCINOMA — Endometrial hyperplasia and carcinoma, as well as the occasional uterine sarcoma, may be detected by properly performed cytologic screening with an accuracy which may approach that of cervical cancer but generally is significantly less. If the cervical canal is patent, which it may not be in the advanced post-menopausal years, the os aspirate provides the optimal specimen for screening of endometrial cancer in the asymptomatic population. For the symptomatic population (post-menopausal staining, bleeding or discharge) endometrial biopsy techniques by curettement or suction biopsy are preferrable.

VAGINAL CARCINOMA — Both invasive and pre-invasive lesions in the vagina should be detected with a high degree of accuracy by exfoliative cytology. When suspected, these lesions are best detected by a gentle scraping of the vaginal membrane.

OTHER CONDITIONS — (1) Malignancy — carcinoma of the ovary, fallopian tube and metastatic carcinoma, especially breast or GI, are occasionally detected by genital cytology; (2) Inflammatory — trichomonas, candida, hemophilus, herpes genitalis.

Technique

To prepare a Pap smear is to request a consultation. The quality of the consultation will reflect the quality of the smear and the clinical data which you provide your consultant, the cytopathologist.

Inspect the cervix carefully. Areas of course texture or reddening are particularly suspect. They should not be present at all in the post-menopausal patients. A true cervical "erosion" is rare. What is usually referred to as erosion is primarily an eversion of the columnar epithelium. The presence of some blood does not render a Pap smear totally useless and should not serve as a contraindication to obtaining the smear, especially in the patient with a history of irregular staining or bleeding.

OS ASPIRATION — Using a large red rubber bulb, as large as possible, with a glass or plastic tubing attached (Available from: Lerner Lab, 207 Greenwich Ave., Stamford, Connecticut 60902, Telephone No. 203-359-0921), preferrably one which is narrowed at the distal tip to allow easier insertion into the cervical canal and to increase the degree of suction, the initial portion of the Pap smear is obtained. Brisk suction within the internal canal and at the external os results in a variable amount of mucus which is expelled in one glob onto the slide. When using a single slide technique, as seems most cost effective, do not spread the specimen this time in order to avoid air drying which introduces artifact.

CERVICAL SCRAPE — This technique, carried out gently to obtain exfoliated cells rather than to scrape cells from the surface, is best performed by using a wooden Ayer spatula rotated at the external os. The material on the spatula is placed on top of the glob of mucus from the os aspirate and these are spread uniformly over the slide with the minimum number of strokes necessary to obtain uniform distribution. Fixative is immediately applied to avoid air drying which introduces artifact.

Supply cytologist with complete data requested on lab slip. He deserves as much information as you would want when a consultation is requested.

COMMON ERRORS — (1) Air drying — Artifact thus introduced interferes with accurate interpretation of the smear due to dehydration of cells; (2) Smear too thick — this obscures screening and can result in failure to detect invasive cancer; (3) Quality of the Cytopathologist — too often the decision as to who should read the Pap smear is made on the basis of cost. Your patient places a great deal of dependence on having had her Pap smear and deserves the best.

Evaluation of the Patient with an Abnormal Pap Smear

The Pap smear is a warning sign and does not necessarily confirm the presence or absence of malignancy. If a grossly abnormal cervix is present, a negative Pap smear does not rule out invasive cancer. Even a positive Pap smear may not

precisely identify the degree of abnormality of cervical neoplasia. How then does one define a presence or absence of cervical neoplasia and its degree?

REPEAT CYTOLOGY — Given the presence of one abnormal Pap smear, a subsequent normal Pap smear, because of the high frequency of high false negative results in this sampling technique, does not rule out the continued presence of cervical neoplasia. If the cytology is to be repeated, this should not be done for a period of 6-8 weeks for reasons which are poorly understood, repetition of the cytology at an earlier interval has an even higher rate of false negative results.

RANDOM CERVICAL BIOPSY — This has no assurance of detecting either any degree of cervical neoplasia nor the maximum degree of abnormality. Its accuracy is improved by selection of biopsy sites from areas which fail to take the Schiller stain.

COLPOSCOPY — This out-patient technique allows visualization of the transformation zone of the cervix utilizing projected light source, magnification, and "developing" solutions to bring out characteristic changes within the epithelium. With this technique, 90% of patient's normal Pap smears can be satisfactorily evaluated on an out-patient basis. Early utilization of colposcopic evaluation avoids the confusion arising from repeated Pap smears and prolonged anxiety to the patient. It also may allow for conservative treatment of pre-invasive lesions with avoidance of hysterectomy.

CONIZATION — Primary conization without previous biopsy as directed by either Schiller stain or, more optimally, by colposcopy, will result in unnecessary conization (as high as 20% of patients). It should be reserved for patients with an unsatisfactory colposcopy or with the suspicion of early invasive cancer as defined on previous biopsy. Conization of the cervix given its expense, hazards, and potential morbidity should be applied to only a limited population.

Fourth Annual Cancer Symposium Set

The Fourth Annual Interdisciplinary Symposium on Cancer Related Problems will be held October 27-28, 1978, at the Woodruff Medical Center, Administration Building, Emory University Campus, 1440 Clifton Road, N.E., Atlanta. The Symposium is sponsored by the Robert Winship Memorial Clinic, Emory University School of Medicine.

The objectives of this year's meeting will be (1) to examine new methods of cancer detection and therapy and (2) to reassess beneficial roles and potential risks of each investigative modality and therapeutic regimen.

Topics of discussion include: Breast Carcinoma and Hormone Receptors; Malignancies of the Female Genital Tract; Sarcomas — Osteogenic and Soft Tissue; Lymphomas and Leukemias. Guest speakers include: Don Clark, M.D., and Alan Turnbull, M.D., Memorial Sloan Kettering, New York; Ned Hornback, M.D., University of Indiana School of Medicine; Roy Wiener, M.D., and William F. Ennekin, M.D., University of Florida School of Medicine; Glenn Warner, M.D., Seattle, Washington.

The featured event is the J. Elliott Scarborough Memorial Lecture at 4:00 p.m., Friday, October 27, with guest speaker R. Lee Clark, M.D., M. D. Anderson Hospital and Tumor Institute in Houston. Dr. Clark will speak on "Present Therapeutic Status of Cancer of the Lung."

For further information, call Emory University Clinic (404) 321-0111, Ext. 303.

heart page
heart page
heart page

Arterial Ischemia of the Lower Extremities—Part 2

PHILIP L. BREWER, M.D., *Columbus**

Reconstructive surgery of the intra-abdominal vessels began in 1951, when Dubost[4] of Paris used an arterial homograft to replace the abdominal aorta of a patient suffering from an aneurysm. Soon, workers in Houston and elsewhere in this country followed and the technic was applied for bypassing arteriosclerotic obstructions, as well as for aneurysm replacement. Homografts were found to be unsuitable because of tissue degeneration, and a wide search was instituted for a more suitable material to replace diseased arteries. Teflon and Dacron, manufactured into knitted, woven and velour conduits have been used extensively, however the most widely accepted substitute is the knitted dacron graft. These grafts, manufactured as either straight or Y-shaped tubes, are flexible, do not degenerate in biological tissues, and allow the ingrowth of tissues through their interstices incorporating a neointima which has little tendency to obstruct the lumen or to result in embolization.

The technics of aortic bypass grafting are well known. Briefly, the operation includes anastomosis of the proximal limb of the graft to the abdominal aorta. We prefer an end-to-end anastomosis at this point rather than the end-to-side technic because of the better flow characteristics and because of less hazard of embolization during the operation. Distally the limbs of the graft may be anastomosed to the external iliac or common femoral vessels. One should bypass as much of the obstructive process as possible, and in many cases the graft is brought downward onto the mouth of the profunda femoris artery. This important vessel supplies the major collateral flow to the lower extremity when the superficial femoral artery is blocked. Occasionally grafts are placed from the axillary artery to the femoral artery subcutaneously or are placed from one femoral artery to the other femoral artery when one side remains patent. These technics have lower long term patency but may be useful for the patient too ill to withstand an intra-abdominal operation.

As with all vascular surgical procedures, attention to technical details is essential for successful results. An everting anastomosis with smooth approximation of the inner surface of the graft to the intima of the artery is desirable. Sutures should be spaced so that hemorrhage and false aneurysm formation are avoided, using care in handling the vessel to avoid detachment of the intima. Flushing of both graft and artery is essential to prevent thrombosis or embolization.

Aneurysms at the anastomotic sites in the aorta or in the lower limbs of the graft, as well as aortointestinal fistuli have now become rare with the replacement of silk suture material by synthetics. Silk is now known to lose approximately three-fourths of its tensile strength within a few weeks after implantation into living tissue,[5] and apparently a strong suture line is required indefinitely to prevent disruption and late aneurysm formation at the junction between prosthetic graft and recipient artery. Anastomotic aneurysms still occur occasionally and have been

(Continued on page 749)

* Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

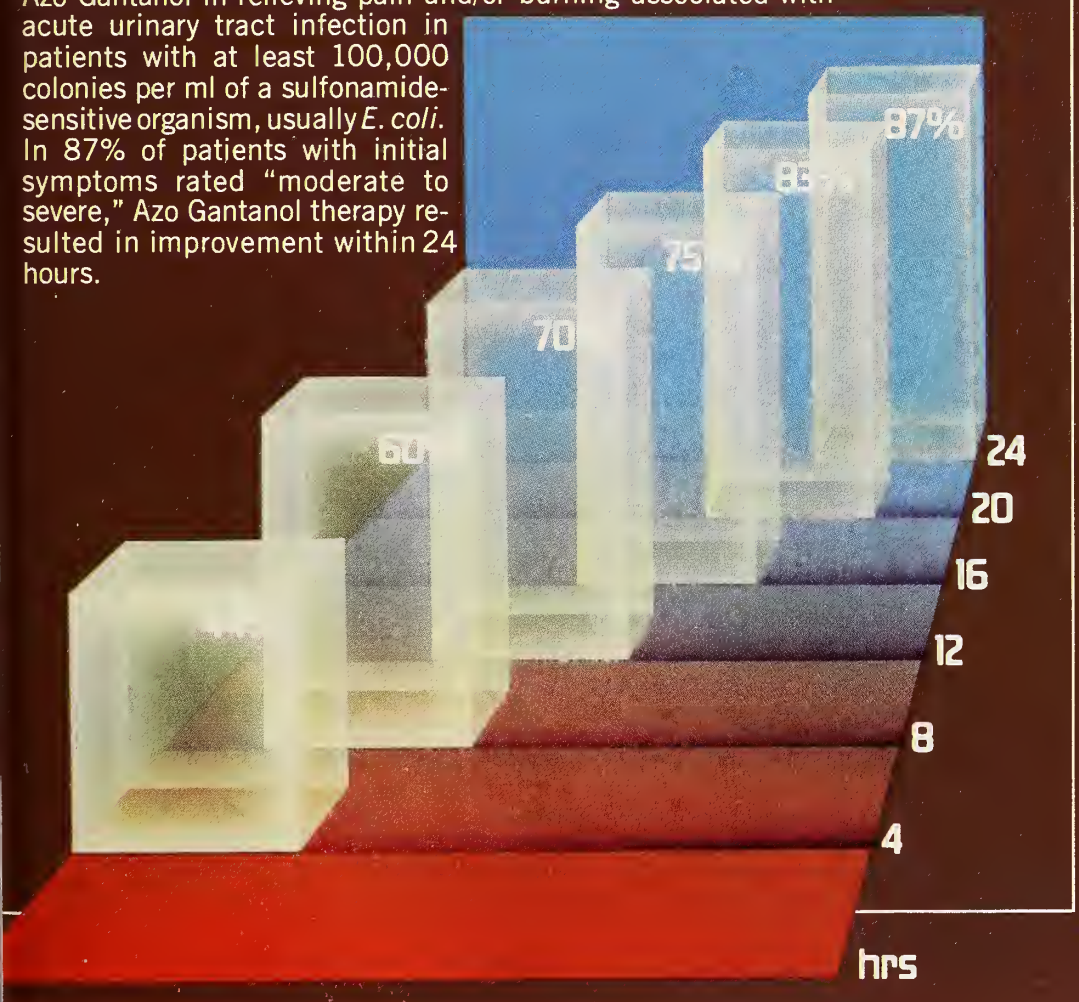
Dr. Brewer's address is Medical Arts Building, Room 201, Columbus, Ga. 31901.

Part 1 of this article appeared in the August issue of the *Journal*.

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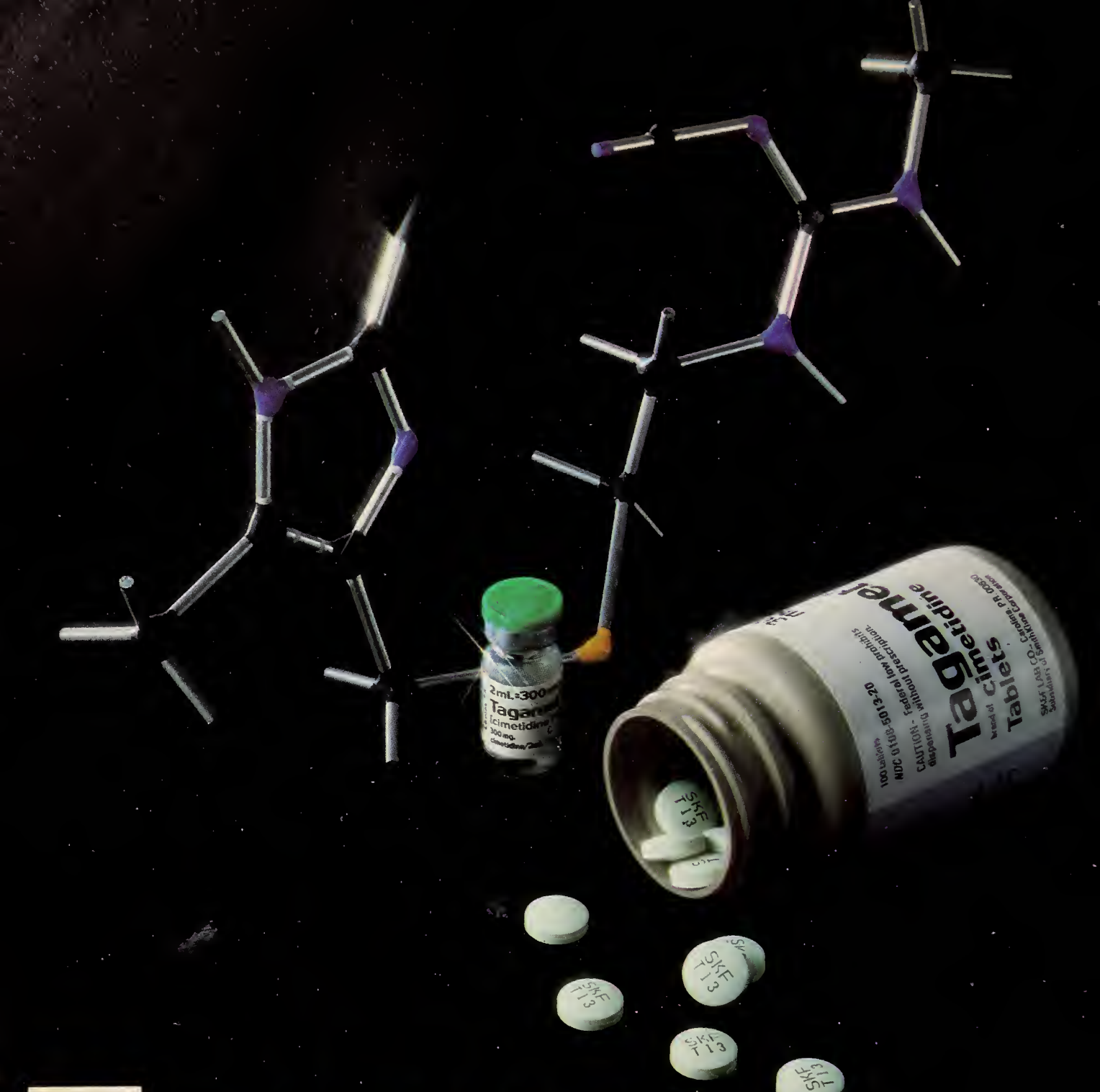
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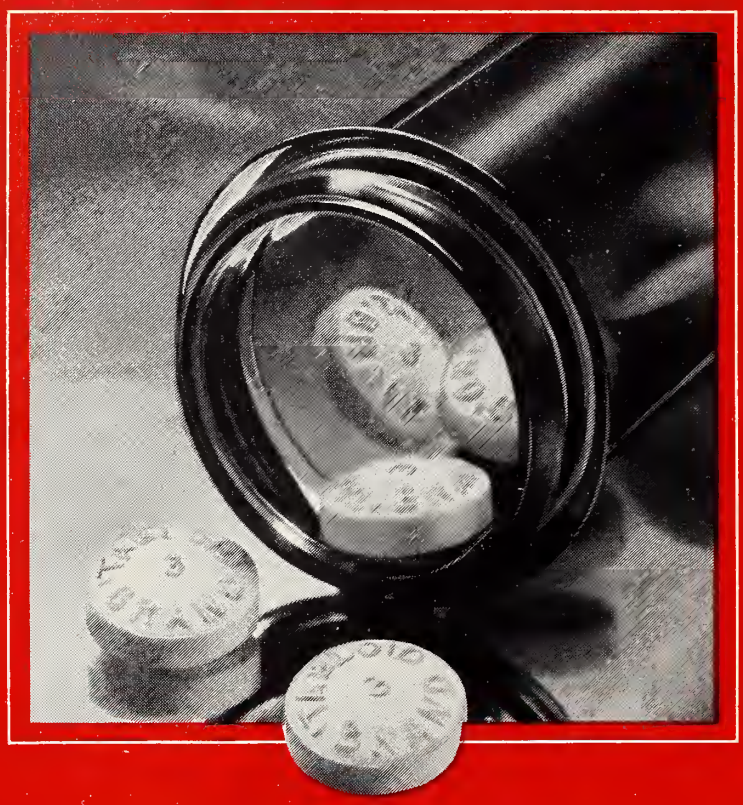
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associated with the use of anticoagulants in the early postoperative period, with infection, and with poor quality distal arteries requiring endarterectomy at the anastomotic site.[6]

The rare complication of lower intestinal infarction, due to division of the inferior mesenteric artery, must be avoided. Ordinarily, division of this artery is of little consequence, however, occasionally a superior mesenteric artery compromise may also be present, making the division of the lower artery disastrous. If this situation is suspected, the inferior mesenteric artery can be reimplanted into the aortic graft. A good rule to follow is that if the inferior mesenteric artery contains a pulsation at the beginning of the procedure, it should be pulsating at the termination.

Finally, a complication that has received little attention until recently is sexual dysfunction following aortic grafting procedures. Varying degrees of preoperative impotency have been noted since the work of Leriche, and has been thought to be due to decreased blood flow through the hypogastric arteries. In addition, certain patients who had no preoperative sexual dysfunction have developed impotency or retrograde ejaculation following operations on the abdominal aorta. This complication can be prevented or markedly reduced by careful dissection preserving the preaortic and presacral nerves.[7]

The results of aortoiliac or aortofemoral bypass procedures are excellent. Patency rates are among the highest of those for any vascular procedure. Early failures are rare, and long term patency is above ninety percent.[8] The risks of the procedure have progressively fallen during the past few years. The previously reported mortality rate of four to five percent[8, 9] should now be considerably reduced, and mortality due to postoperative complications, such as bleeding, thrombosis, or infection should be rare. The major reasons for decreasing mortality are better preoperative evaluation and improved postoperative care. In the past, when postoperative deaths occurred, they were often attributable to other complications of arteriosclerotic disease, primarily cerebral thrombosis or myocardial infarction. By identifying patients with associated signs or symptoms of cerebral vascular disease or arteriosclerotic heart disease using cerebral or coronary angiography as needed, corrective procedures on the carotid or coronary vessels can be carried out prior to attempts to restore lower extremity circulation.

Advances in intraoperative and postoperative care include constant arterial monitoring with intra-arterial cannulae, central venous or pulmonary wedge pressure monitoring, and the assurance of adequate oxygenation and ventilation during the early postoperative period with use of a mechanical ventilator. Prophylactic antibiotics and low-dose heparin therapy are routinely used. Elevation of the legs to increase venous flow[10] as well as early active lower extremity exercises are other measures thought to be helpful in preventing thromboembolism. Careful attention should be paid to the avoidance of decubitus ulcers of the heel by foam rubber padding, used both during and after the operation. The development of an ulcer in this area following an otherwise successful operation is an avoidable and unfortunate complication. We have found that our patients are more comfortable with gastrostomies than with indwelling nasogastric tubes and feel that oropharyngeal and tracheal secretions may be reduced by this procedure. Finally, intensive pulmonary toilet and early ambulation are instituted as the patient's recovery progresses.

For procedures performed below the inguinal ligament, that is, on the arteries of the legs themselves, prosthetic grafts are less suitable. Alexis Carell[11] first demonstrated the use of vein as an arterial substitute in the early years of this century, however, it was not until the 1940's that another Frenchman, Kunlin,[12] used autogenous saphenous vein for bypassing obstructive lesions in the femoral-popliteal system. These technics of saphenous vein bypass grafting were advocated in this country by Linton, Darling,[13] Dale,[14] and others, and have been the procedures of choice when reconstructive arterial surgery of the lower extremity is required. Dacron grafts have been less desirable in these smaller arteries because of

the high failure rate, which is probably related to kinking of the graft which occurs on genuflection whenever the graft is carried across the knee joint.

The technics of femoral to popliteal saphenous vein bypass grafting can be outlined briefly. The vein is carefully excised along its course on the medial aspect of the leg, ligating all branches. It is then gently inflated with a cold solution of colloid or blood and sewn, usually with end-to-side anastomoses, in a reverse direction so that the valves within the vein do not impede flow, to the popliteal artery below and to the common or superficial femoral artery above. Placing the vein in this manner bypasses the obstruction which usually occurs in the superficial femoral or proximal popliteal arteries. Again, technical details are important requiring widely patent anastomoses, intima to intima approximation of vein to artery, and careful placement of the vein so that redundancy and tension are avoided. Usually the graft must reach the distal popliteal artery which may be approached by dividing the medial head of the gastrocnemius muscle as advocated by Szilagyi.[15] Postoperative care is similar to that following aortic procedures except that mechanical ventilation after operation and gastrostomies are not required.

In recent years, the saphenous vein technic has been extended, bypassing onto the anterior tibial, posterior tibial, or peroneal arteries when the popliteal vessel has been completely obliterated. This is an extremely useful modification for salvaging ischemic limbs with advanced disease. Although procedures on the lower extremities have a lower operative mortality than aortic bypass grafting, the patency rates are somewhat less. For femoropopliteal bypass, an immediate patency rate of eighty-five to ninety-five percent and a sixty to seventy percent patency at five years can be expected.[16-17] For femoral-tibial procedures immediate success is less, but long term figures are similar or slightly better than those for femoropopliteal bypasses.[18]

Lumbar sympathectomy is a frequently performed operation for patients with obstructive arteriosclerosis of the lower extremity. As an isolated procedure the effect of sympathectomy on the course of arteriosclerotic disease and on the relief of symptoms is, at best, equivocal.[19] When combined with bypass procedures at the aortoiliac or femoral-popliteal level, however, sympathectomy seems to have real benefit by decreasing peripheral resistance and increasing flow through the grafts.[20]

In conclusion, when confronted with a patient suffering from arterial insufficiency of the lower extremities, a decision as to the proper course of therapy must be made. If surgery is being considered, one must first ask the risk of operation and the chance of success. Finally, one must ask if the symptoms warrant operation. The risk and chances of success have been discussed above. To recapitulate, aortoiliac bypass grafting is a major undertaking, but with modern technics can be performed with a low mortality rate. The success rate in terms of restoration of pulses and, importantly, maintenance of pulses is excellent. With femoral-popliteal grafting the mortality is even less, however, the chances of success are not as great and with grafts to the more distal arteries, such as femoral-tibial bypasses, patency rates are further reduced.

In order to ascertain whether the symptoms warrant surgery, one must have some idea of the natural history of the disease. There are few such studies, however, those available[19] would indicate that the prognosis for claudication is reasonably good. In fact, after the onset of claudication, one can expect some gradual improvement during the following year as collaterals develop. Limb loss is certainly not an immediate consequence of mild or moderate claudication. If, however, claudication progresses and becomes severe, or if rest pain or tissue necrosis intervene, loss of limb becomes a threat.

Knowing the above, we have evolved the following approach. For patients with bothersome claudication due to aortoiliac occlusive disease, we recommend operative intervention if there are no important medical contraindications. We feel justified in this approach by the strikingly good relief of symptoms obtained and by the likelihood that the relief will be longstanding. The problem of patients with

claudication due to femoral-popliteal disease is another matter. Certainly, the elderly lady whose major activity is walking from her kitchen to the front porch, and who only has claudication on extreme exertion is not a candidate for a saphenous vein bypass procedure. A fifty-year-old mailman, with claudication threatening his livelihood is the opposite extreme, and if good runoff is present, a femoral-popliteal bypass is worthwhile.

For patients threatened with limb loss, a more aggressive approach is indicated. Often multiple blocks, both at the aortoiliac level and in the arteries of the extremity are present. In such instances, the more proximal lesion should be corrected first, and often an aortoiliac or an aortofemoral bypass will relieve the patient's symptoms to a degree that he is comfortable and a bypass procedure on the leg itself need not be performed. In patients with rest pain or tissue necrosis and disease in the superficial femoral artery, in the popliteal artery, or at the origin of the tibial vessels, a saphenous vein bypass can be strongly urged. These procedures are justified on the basis of limb salvage even though patency rates are somewhat less than for bypass to the larger arteries. The relief of pain and reversal of early gangrenous changes in a patient who is otherwise certain to require a major amputation are gratifying results.

In summary, arteriosclerotic obstructive disease of the lower extremities presents a variable clinical picture which taxes the ingenuity of the clinician. Experience, expert angiography, and a thorough knowledge of what the various operative procedures have to offer, as well as the natural history of the arteriosclerotic process, are essential to making the right decisions for treatment.

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"Racial Quotas" v. "Racial Awareness": What *Bakke* Demands of Medical School Admissions Programs

ROBERT N. BERG, *Atlanta**

THE QUESTION, WHEN STRIPPED of its political, social and ideological overtones, was relatively simple: may a medical school lawfully discriminate in its admissions program in favor of members of disadvantaged minorities? The answer, when similarly viewed in a vacuum of purely legalistic reasoning, was equally simple: a medical school may not employ rigid quotas, based solely on race, to give preference in its admissions program to disadvantaged minorities, although race might legitimately be employed as one of the many factors utilized in judging students for admission. Despite this apparent simplicity, however, the question posed in *Regents of the University of California v. Bakke*[1] was immensely complex, a question which required an analysis of a myriad of political, social, cultural and ideological, as well as legal, factors. Moreover, the answer, provided by a slim majority of the United States Supreme Court, was an extremely important one, a decision which would ultimately be felt in a wide range of areas, including professional school admissions, equal opportunity employment and affirmative action voting programs.

Perhaps because of the fact that the *Bakke* decision is, in its most simple form, susceptible to broad generalizations (e.g. "*Bakke* affirms affirmative action programs"), it is easy to overlook the fact that the *Bakke* decision provides several guidelines for and requirements of professional school admissions programs. Consequently, this article will attempt to answer the question of what *Bakke* demands of medical school admissions programs.

The Bakke Decision

Briefly, Allan Bakke unsuccessfully applied, in 1973 and again in 1974, for admission to the University of California at Davis Medical School under its "regular admissions" program. He subsequently challenged his rejections on the grounds that they were the result of the University's "special admissions" program, whereby 16 of the 100 admissions places were reserved for students of disadvantaged minority groups; Bakke claimed that, because he was better qualified for admission than were the minority applicants who were accepted pursuant to the special admissions program, he had been the victim of invidious racial discrimination.

The Supreme Court of California agreed,[2] holding that the use of race as a factor in making admissions decisions was unlawful, and ordering the University to admit Bakke to the medical school.[3]

The United States Supreme Court, in an opinion written by Justice Powell for a

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

five-justice majority of the Court, affirmed the California court's decision that the University's special admissions program unlawfully violated Title VI of the 1964 Civil Rights Act,[4] which prohibits racial discrimination in any federally funded program; as stated by the Court: "The guarantee of equal protection cannot mean one thing when applied to one individual and something else when applied to a person of another color. If both are not accorded the same protection, then it is not equal."[5]

As to the California court's holding that the use of race as a factor in admissions decisions was in and of itself unconstitutional, the Supreme Court, with Justice Powell writing for a different five-justice majority,[6] reversed, holding that the use of race as one of several factors involved in the admissions decision-making process was justified by substantial state interests, both in ameliorating the disabling effects of past discrimination and in obtaining a diverse student body so as to ultimately provide greater contributions by its students to all areas of society. It is in this portion of the opinion that the Court offered some guidance as to the question of how an admissions program may lawfully take race into account.

"Racial Awareness" and the Medical School Admissions Program of the Future

The crucial distinction between an unlawful admissions program, such as the one employed by the University in *Bakke*, and a lawful admissions program, lies in the difference between a "racial quota" and what may become the catchword for future professional school admissions programs, "racial awareness." Thus, the medical school admissions program which designates a certain number of places for disadvantaged minority students,[7] or one which focuses *solely* on race in making its admissions decisions, will not be tolerated; conversely, the medical school admissions program which utilizes race as one of many factors (i.e. is "aware" of race as *a* factor) in making its decisions will be acceptable.

Justice Powell's opinion in *Bakke* cites two examples, Harvard and Princeton, which exemplify the type of "racially aware" admissions program which places a lawful emphasis on race. The gist of these admissions programs is that race (or ethnic background), while deemed a "plus" in a particular applicant's file, does not insulate the individual from comparison with all other candidates for the available seats. Consequently, an applicant's race or ethnic background would be viewed with and compared to other qualities which indicated an applicant's capability for potential contributions as a professional; these other qualities, as listed by the Court, could include: exceptional personal talents, unique work or service experience, leadership potential, maturity, demonstrated compassion, a history of overcoming disadvantage, an ability to communicate with the poor, or other qualifications deemed important.[8]

What Bakke Demands of Medical School Admissions Programs

The clear import of the *Bakke* decision is that educational institutions will be free from judicial interference if they act in good faith in adopting and implementing "racially aware" admissions programs; "[s]o long as the university proceeds on an individualized, case-by-case basis, there [will be] no warrant for judicial interference in the academic process."[9] In this light, the *Bakke* decision may be viewed as simply demanding that medical schools have sufficient documentation of their "good faith" efforts to create "racially aware" admissions programs so as to justify the "presumption of legality"[10] accorded by the Court. If the decision is nothing more than a requirement to keep "clean" files, however, there are those who will correctly argue that *Bakke* merely authorizes medical and other professional schools to adopt "facially nondiscriminatory admissions programs" which are "simply a more subtle and more sophisticated — but no less effective — means of according racial preference. . . ."[11]

In a more positive light, however, *Bakke* may be seen as a decision by the Supreme Court to place the burden of creating the "racially aware" admissions programs of the future on the medical and other professional schools, rather than on

the courts. The message of the *Bakke* decision may in fact be that educational institutions, through the implementation of admissions programs such as the ones at Harvard and Princeton, and through the constant refinement of these programs, have the opportunity to wrestle with the important social, cultural and ideological problems on their own, and, as long as it is done in good faith, to determine the rightful place for race or ethnic background as a factor in the admissions decision-making process. When viewed in this light, the *Bakke* decision makes a significant demand on medical school admissions programs: it demands that they accept the Supreme Court's challenge to shape their own futures through the creation of "racially aware" admissions programs.

Notes

1. —— U.S. ——, 46 U.S.L.W. 4896 (June 28, 1978).
2. 18 Cal.3d 34, 553 P.2d 1152, 132 Cal.Rptr. 680 (1976).
3. For a more comprehensive look at the factual and legal issues involved in *Bakke*, see my article entitled "Regents of the University of California v. Bakke: Must Medical School Admissions Programs Be 'Color-Blind'?," *Journal of the Medical Association of Georgia*, Volume 66, No. 11, at 907-908 (November, 1977).
4. 42 U.S.C. §2000d.
5. *Bakke, supra,* at ——, 46 U.S.L.W. at 4901, 4902.
6. The five-Justice majority of the Supreme Court upholding the lower Court's decision that the University's special admissions program was unlawful was composed of Justices Powell, Burger, Stewart, Rehnquist and Stevens. The five-Justice majority of the Court reversing the lower court's decision that the use of race as a factor in the admissions decision-making process was unlawful was composed of Justices Powell, Brennan, White, Marshall and Blackmun.
7. The Court summarily treated and dismissed the University's contention that the special admissions program involved the setting up of "targets" or "goals" rather than "quotas." —— U.S. at ——, 46 U.S.L.W. at 4901.
8. *Bakke, supra,* at ——, 46 U.S.L.W. at 4909.
9. *Bakke, supra,* at note 53, 46 U.S.L.W. at 4909.
10. *Bakke, supra,* at ——, 46 U.S.L.W. at 4909.
11. *Id.*

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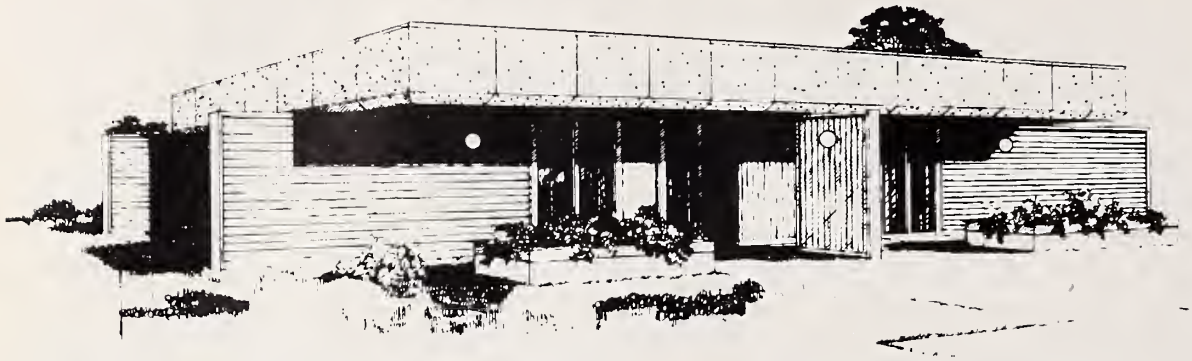


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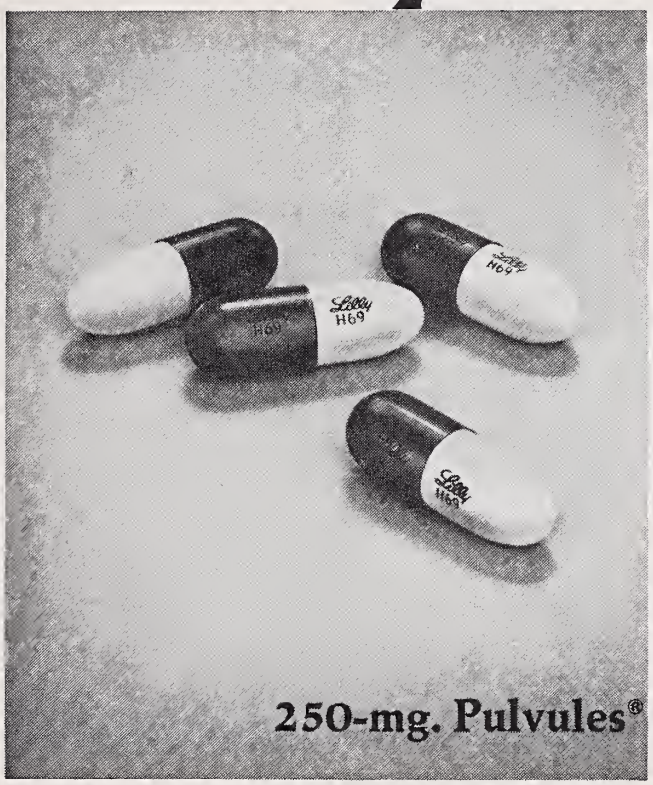
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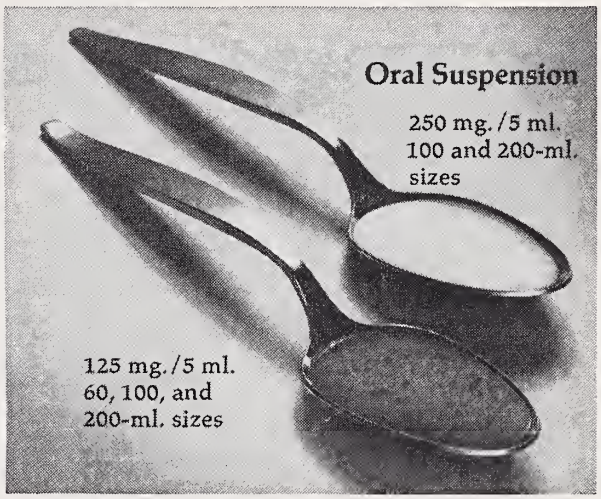
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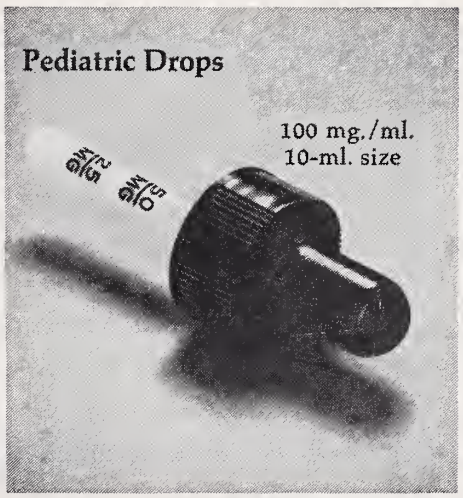
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SOCIETIES

At its July meeting, the **DeKalb Medical Society** heard astronaut William Thornton from NASA and the Johnson Space Center, Houston, Texas. He spoke on "Medicine in the Shuttle Area."

PERSONALS

First District

J. M. Byne Jr., M.D., Waynesboro, retired recently after almost 50 years in medicine. He was chief of staff of the Burke County Hospital since its conception in 1951.

Katrine Hawkins, M.D., completed CME requirements to retain active membership in the American Academy of Family Physicians.

Second District

James H. Crowdis Jr., M.D., Blakely, and **Robert T. Morgan, M.D.,** Sylvester, have completed CME requirements to retain active membership in the American Academy of Family Physicians.

Fourth District

Chamblee physician **Lawrence Freeman, M.D.,** and Warm Springs physician **Howell A. Wasden III, M.D.,** have been named diplomates of the American Board of Family Practice.

Clyde Harrison, M.D., Forest Park, has been appointed a member of the board of the Clayton County Hospital Authority.

Fifth District

Atlanta urologist **Harvey E. Merlin, M.D.,** recently took office as chief of the medical staff at South Fulton Hospital. **Hugo S. Moreno, M.D.,** was made chief-of-staff-elect. Other MAG-member officers include: **Gordon Goldstein, M.D.,** secretary for the staff; **Fernando Duralde, M.D.,** chief of surgery; **Bozidar Voljavec, M.D.,** chief of OB/Gyn; **Gabriel F. Nassar, M.D.,** vice chief of OB/Gyn; **Thomas P. Scott, M.D.,** chief of pediatrics; **Edmond Green, M.D.,** vice chief of pediatrics; **Herman Becerra, M.D.,** vice chief of family practice; **H. V. Bell, M.D.,** chief of pathology; **Clyde Black, M.D.,** chief of radiology; **J. I. Kim, M.D.,** chief of anesthesiology.

Carl A. Smith., M.D., has been elected president of the Greater Atlanta Society of Anesthesiologists. New vice president is **John B. Neeld Jr., M.D.,** and secretary-treasurer is **J. N. Hill III, M.D.**

Sixth District

Forsyth physician **Senen J. Encinas, M.D.,** and **Seab E. A. Reeves, M.D.,** Dublin, have completed CME requirements to retain active membership in the American Academy of Family Physicians.

Hugh Smisson, M.D., Macon, is president-elect of the Georgia Neurosurgical Society.

The Medical College of Georgia has selected **Hoke Wammock, M.D.,** "Sesquicentennial Alumni Ambassador" during the college's 150th anniversary celebration this year. Dr. Wammock, director of Enoch Callaway Cancer Clinic in LaGrange, is a member of the college's centennial graduation class and has served as president of the School of Medicine Alumni Association.

Seventh District

Richard Cohen, M.D., has been elected president of ARC's Human Services Advisory Council.

Rome physician **Harry E. Dawson Jr., M.D.,** has been certified by the American Board of Plastic Surgery.

Noel Holtz, M.D., has been certified in neurology by



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the American Board of Psychiatry and Neurology.

Mableton internist **C. David Markle, M.D.,** was elected president of the medical-dental staff of Cobb General Hospital.

Roy M. Rubin, M.D., recently spent four weeks as an American Orthopedic Association North American Traveling Fellow, visiting outstanding orthopedic centers throughout the U.S. and Canada. He was one of five fellows in the U.S. selected to participate in this prestigious tour.

Ninth District

W. W. Harris, M.D., Royston, has completed CME requirements to retain active membership in the American Academy of Family Physicians.

DEATHS

Samuel Uland Braly

Samuel Uland Braly, M.D., died July 4 after a sudden two-day illness. He was 52.

Born in Henderson, Tennessee, he was a graduate of the University of Tennessee and the University of Tennessee Medical School in Memphis. He was a general practitioner and surgeon and was a resident of Paulding County for the past 25 years.

Dr. Braly had served as vice chairman of the Paulding Memorial Hospital Authority and as state senator from Paulding County. At the time of his death, he was chief of staff of Paulding Memorial Hospital.

Survivors include his wife, Jo Ann Womack Braly; six daughters; two sons; his mother.

Claude Victor Vansant Sr.

Claude Victor Vansant Sr., M.D., died June 9 at the age of 91. The Douglasville physician had been practicing medicine since 1911.

During WWI and WWII, he received citations from four U.S. Presidents. He was a former director of the Commercial Bank.

Dr. Vansant reportedly delivered over 9,000 babies during the course of his practice, and was still treating patients until he was hospitalized shortly before his death.

Survivors include his wife, Anna Mary Vansant; one daughter; seven grandchildren; one great granddaughter.

All Specialties at 1978 Scientific Assembly

Georgia's World Congress Center in Atlanta will provide the setting for MAG's fourth consecutive fall Scientific Assembly on November 11-14, 1978. In what will be a new approach to continuing medical education, the MAG and the Southern Medical Association are combining for this meeting, and overall attendance is projected at over 3,000.

For the first time, this year's Assembly will offer scientific sessions in all specialties, with the active planning and support of the 23 major specialty societies in Georgia. Each specialty society program chairman has worked closely with SMA's section chairman in selecting topics and speakers of greatest interest to the practicing physician.

Special guest speakers will include: Oscar Frick, Al-

lergy; John Downs, Anesthesiology; Joseph Civetta, Chest Diseases; Donald Birmingham, Dermatology; James George, Emergency Medicine; Jack Froom, Family Practice; Eugene Schiff, Gastroenterology; Irvin Kricheff, Neurosurgery; Kamran Moghissi, Gynecology; Jay Sanford, Medicine, and Fritz Dreifuss and Redford Williams, Neurology. Guest speakers in other specialties will be announced in the October *Journal*.

Postgraduate courses with limited enrollment will be offered in 17 subjects, including Gynecologic Oncology, Liver Disease, Cardiology, Common Hand Injuries, Head and Neck Surgery, Acne, Pediatric Urology, and Dermatology for the non-dermatologist.

MAG's annual Luncheon and Abner W. Calhoun Lecture on Saturday, November 11, will be open to all Assembly attendees and their spouses. In addition, a most attractive spouses' program will feature mini-courses, tours and demonstrations. Specialty societies and medical school alumni groups will be holding special receptions, dinners and luncheons.

One of the most attractive features of this year's Assembly is that it will be free to all members of the MAG or the SMA. Registration fee for non-members is $20. This represents a real bargain in continuing education, with some 260 total available hours of AMA Category 1 credit.

For more information, contact Scientific Assembly at the MAG office, (404) 876-7535 or WATS (800) 282-0224.—**S.L.D.**

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On being an executrix
Selling (or dissolving) the practice
Creating cash at the proper time

Registration forms for MAGNET '78, along with hotel reservation cards, have been sent to all MAG members. If you have not registered, please complete the form below and send to: MAGNET '78, 938 Peachtree Street, N.E., Atlanta, Ga. 30309. For hotel reservations, contact the Terrace Garden Inn in Atlanta at (404) 261-9250.

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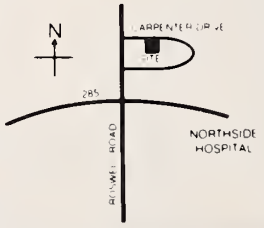
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Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

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of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

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- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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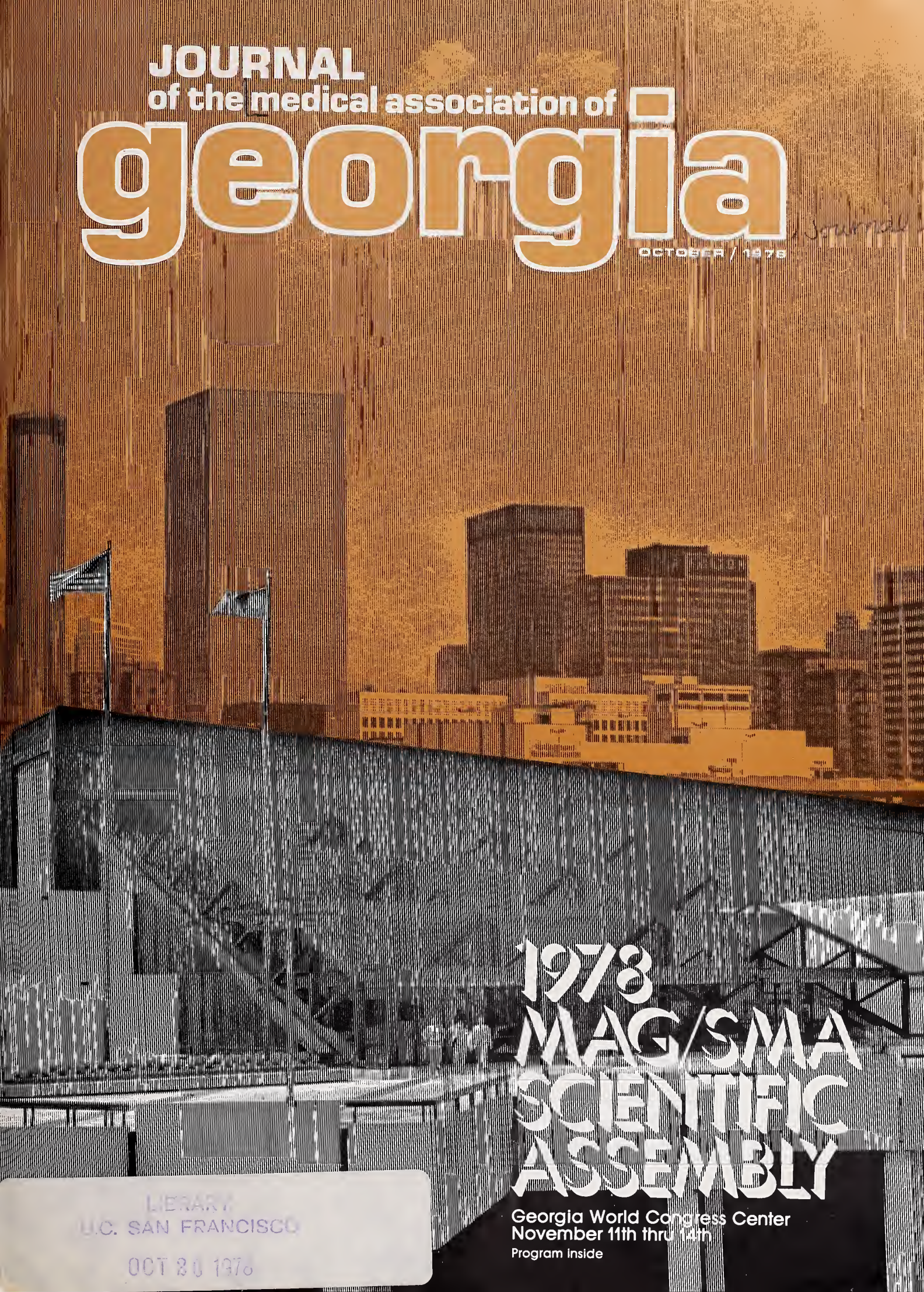
The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of intr colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal trac

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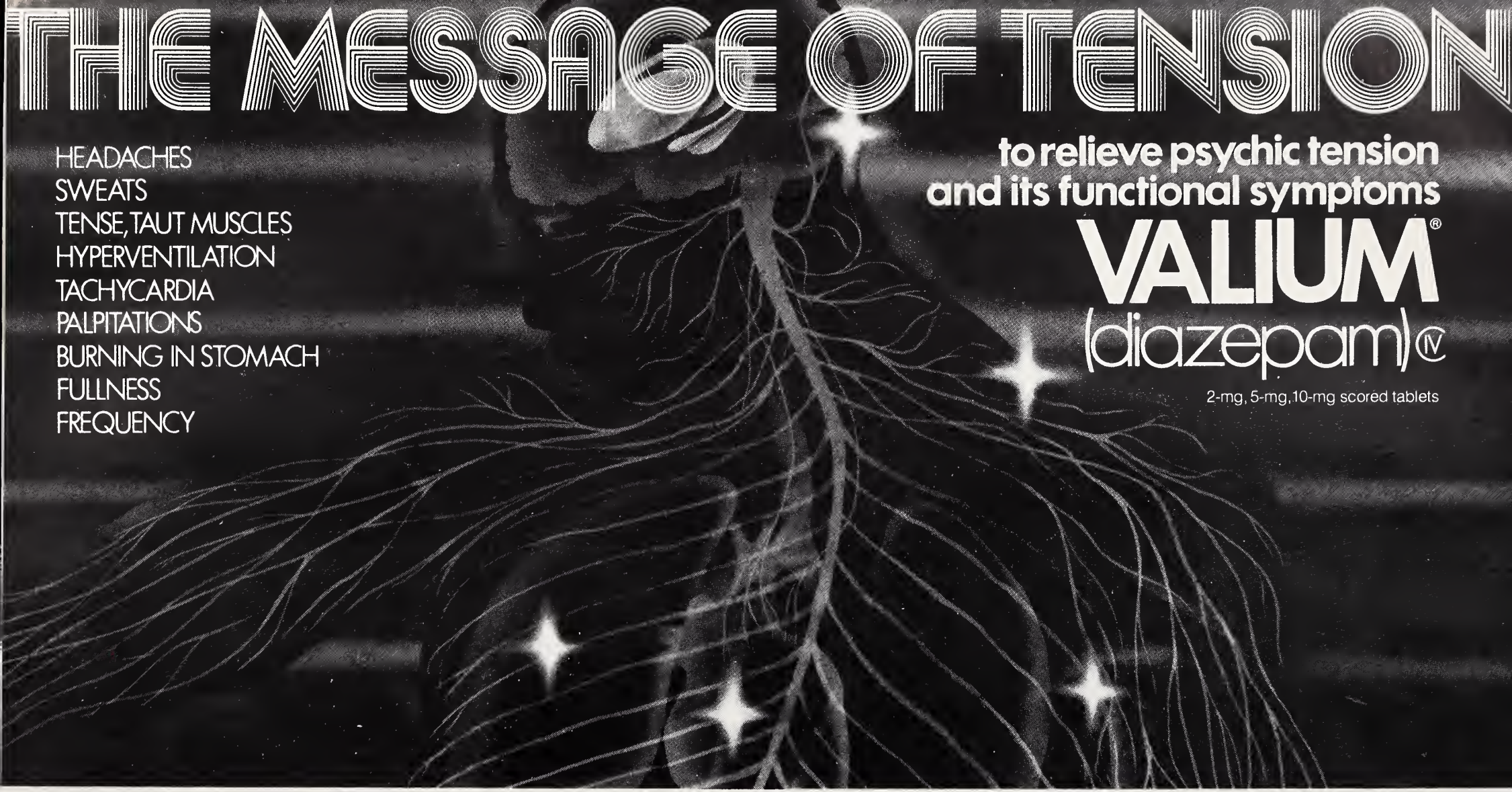
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VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Adverse Reactions: Drowsiness, fatigue, confusion, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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THE COVER

The Georgia World Congress Center, site of the 1978 MAG/SMA Scientific Assembly, is superimposed on the skyline of beautiful Atlanta, the host city. Physicians from all over the South will be converging on that city in November to attend MAG's largest Scientific Assembly ever. For details on this exciting event, see pages 782-786 and 789-801. Cover design by Bob Hamill.

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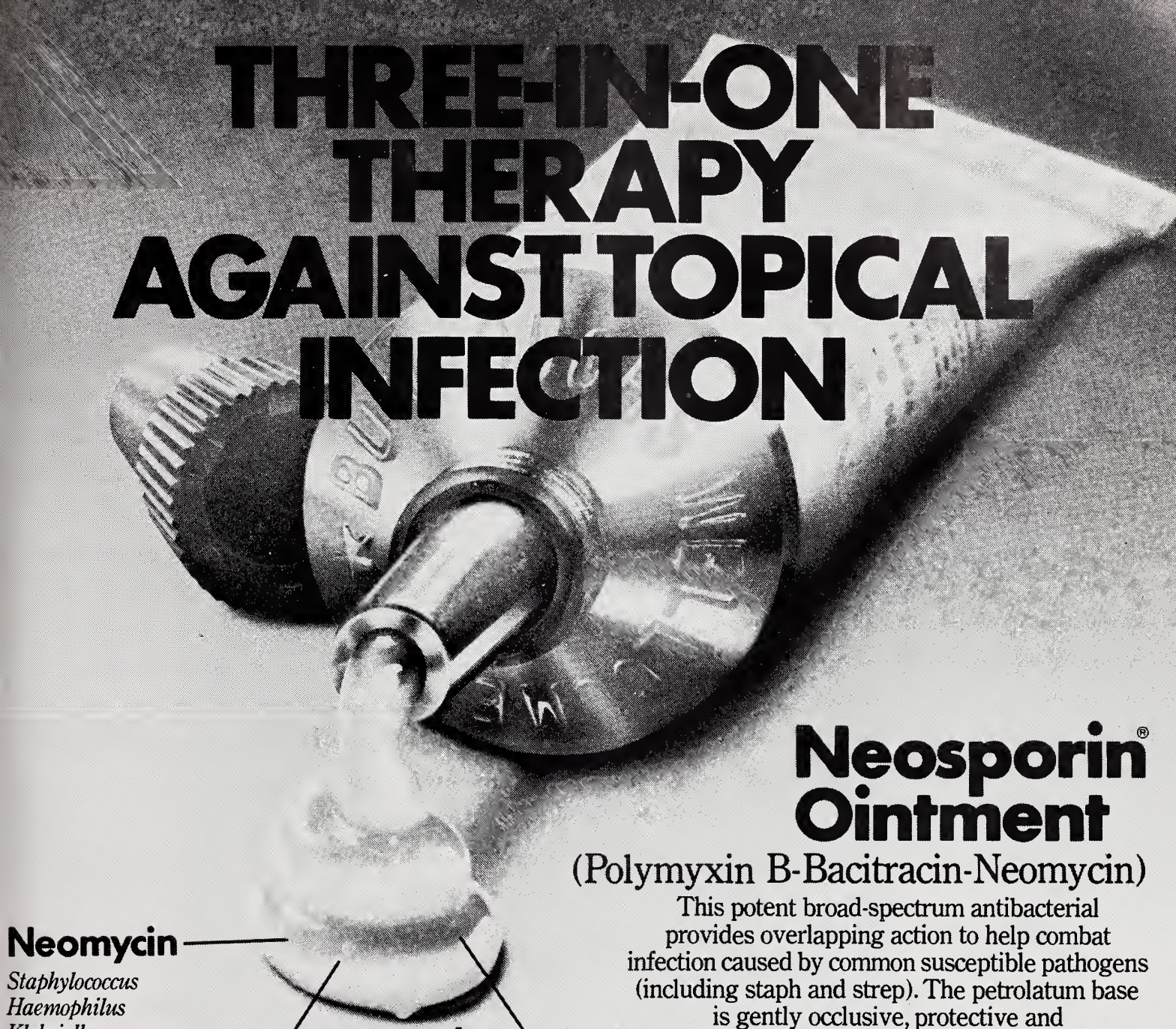
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Complete literature available on request from Professional Services Dept. PML.

MEDICAL MEETING CALENDAR

OCTOBER

24-27—*Atlanta;* **CLINICAL EMG BIOFEEDBACK TRAINING COURSE;** Contact: Steven L. Wolf, Ph.D., Center for Rehabilitation Medicine, 1441 Clifton Rd., Atlanta 30322.

27—*Pine Mountain;* **SYMPOSIUM OF RHEUMATIC DISEASES;** Category 1 Credit; Contact: Dr. John Vansant, The Medical Center, Columbus 31902.

27-28—*Atlanta;* **FOURTH INTERDISCIPLINARY SYMPOSIUM ON CANCER-RELATED PROBLEMS;** Category 1 Credit; Contact: CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

27-28—*Savannah;* **SOUTHEASTERN REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Nicholas E. Davies, M.D., 35 Collier Rd., N.W., Atlanta 30309.

27-29—*Atlanta;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 Credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

30-November 4—*Atlanta;* **ANNUAL MEETING, GEORGIA ACADEMY OF FAMILY PHYSICIANS;** Contact: GAFP, 11 Corporate Sq., Suite 205, Atlanta 30329. PH: 404/321-7445.

NOVEMBER

2—*Atlanta;* **PRACTICAL MANAGEMENT OF INFECTIONS IN THE NEWBORN AND YOUNG INFANT;** Category 1 Credit; Contact: James S. Maughon, M.D., 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211.

3-4—*Atlanta;* **PHYSIOLOGIC SYSTEM UPDATE;** Category 1 Credit; Contact: CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

6-9—*Augusta;* **LAPAROSCOPY AND COLPOSCOPY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

7-11—*Hilton Head, SC;* **SOUTHEASTERN OCCUPATIONAL HEALTH AND SAFETY CONFERENCE;** Contact: D. H. Robinson, M.D., Box 21372, Columbia, SC 29221.

8—*Greenville, NC;* **PRACTICAL PEDIATRICS;** Category 1 Credit; Contact: F. M. Simmons Patterson, M.D., East Carolina University School of Medicine, Greenville, NC 27834.

8—*Knoxville, TN;* **NEW DEVELOPMENTS IN RADIOLOGY;** Contact: Knoxville Academy of Medicine, 422 West Cumberland, Knoxville, TN 37902.

9-10—*Louisville, KY;* **12TH ANNUAL NEWBORN SYMPOSIUM;** Category 1 Credit; Contact: Gerald D. Swim, University of Louisville School of Medicine, Health Sciences Center, P.O. Box 35260, Louisville, KY 40232.

9-11—*Atlanta;* **SYMPOSIUM ON THE MANAGEMENT OF ACUTE TRAUMA;** Contact: Ms. S. L. Weed, 875 N. Michigan Ave., Suite 3010, Chicago, IL 60611.

10—*Winston-Salem, NC;* **SEMINAR ON AGING;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27103.

10-11—*Atlanta;* **DIAGNOSTIC LAPAROSCOPY MEETING;** Contact: V. M. Smith, M.D., 301 St. Paul Place, Baltimore, MD 21202.

11-14—*Atlanta;* **MAG-SOUTHERN MEDICAL ASSOCIATION ANNUAL SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Sue McAvoy, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

13—*Knoxville, TN;* **NEW DEVELOPMENTS IN SURGERY;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

13-14—*Jacksonville, FL;* **CLINICAL FAMILY PLANNING FOR PHYSICIANS;** Contact: James A. O'Donnell, M.D., 655 W. 8th St., Jacksonville, FL 32209.

13-17—*Louisville, KY;* **MICROSURGERY FOR GYNECOLOGISTS;** Category 1 Credit; Contact: Gerald D. Swim, University of Louisville School of Medicine, Health Sciences Center, P.O. Box 35260, Louisville, KY 40232.

14—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE, PEDIATRICS, UROLOGY;** Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

15-17—*Charleston, SC;* **SOUTHEASTERN CANCER RESEARCH ASSOCIATION ANNUAL MEETING;** Contact: Dr. D. Scott, Dept. of Cellular-Molecular Biology, Medical College of Georgia, Augusta 30902.

15-19—*Atlanta;* **ANNUAL MEETING, ACADEMY OF PSYCHOSOMATIC MEDICINE;** Category 1 Credit; Contact: Donn W. Sanford, Academy of Psychosomatic Medicine, 4902 Tollview Dr., Rolling Meadows, IL 60008.

16-17—*Winston-Salem, NC;* **TWO-DAY REAL TIME COURSES FOR OBSTETRICIANS;** Category 1 Credit; Contact: James F. Martin, M.D., Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem, NC 21703.

29—*Sanford, NC;* **NUTRITION IN MEDICAL CARE 1978;** Contact: R. S. Cline, M.D., Lee County Hospital, Sanford, NC 27330.

29-December 3—*Atlanta;* **THIRD SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ADDICTION;** Contact: Conway Hunter Jr., M.D., Peachford Hospital, 2151 Peachford Rd., Atlanta 30338. PH: 404/455-3200.

DECEMBER

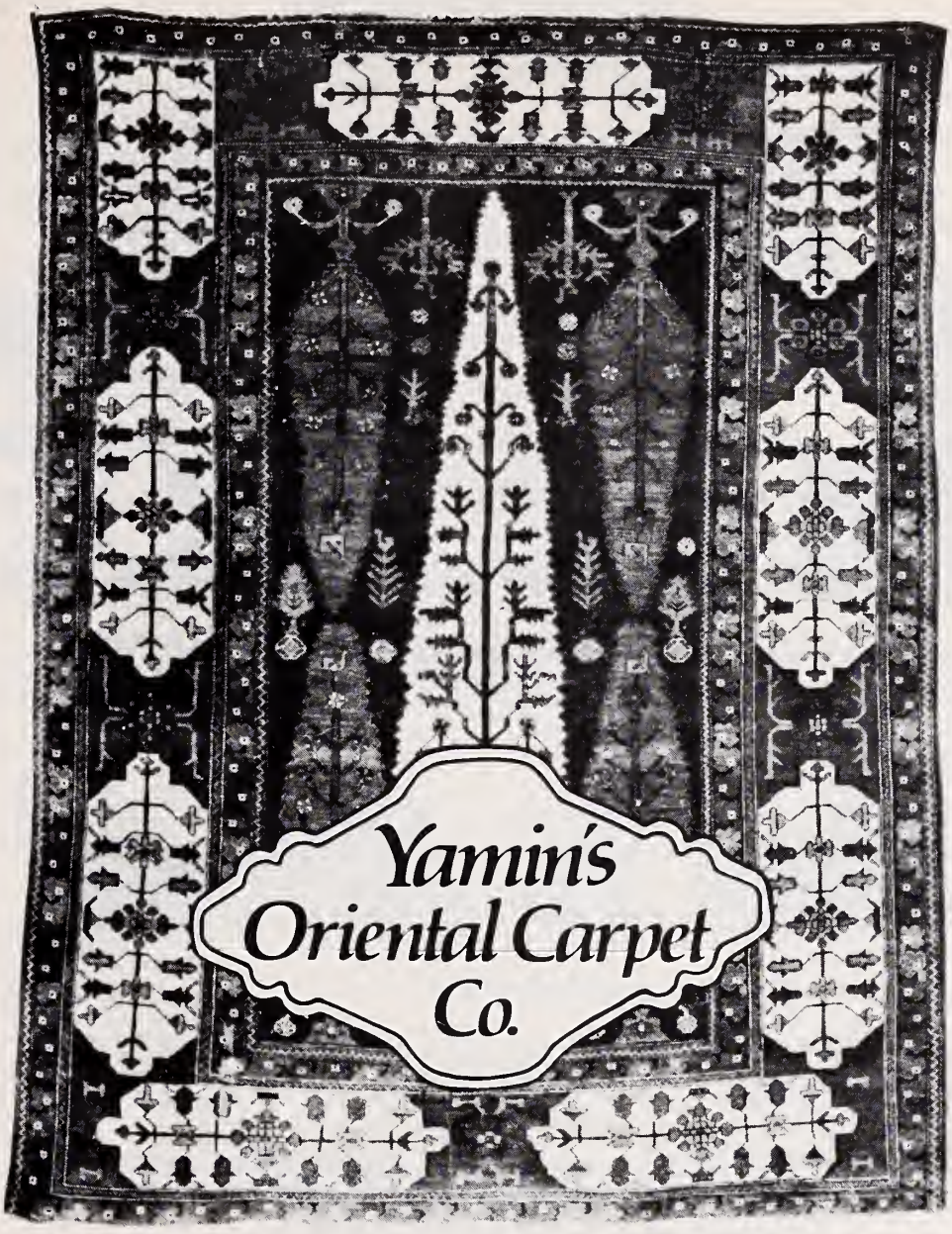
7-8—*Atlanta;* **CURRENT CONCEPTS IN ANTERIOR SEGMENT SURGERY AND DISEASE;** Category 1 Credit; Contact: CME, 69 Butler St., S.E. Atlanta 30303. PH: 404/588-3534.

7-8—*Augusta;* **FAMILY DYNAMICS;** Contact: Division on Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

7-10—*Las Vegas, NV;* **AMA WINTER SCIENTIFIC PROGRAMS;** Category 1 Credit; Contact: James H. Sammons, M.D., 535 N. Dearborn St., Chicago, IL 60610.

8—*Atlanta;* **FOURTH ANNUAL HOLIDAY INFECTIOUS DISEASES SEMINAR;** Category 1 Credit; Contact: James S. Maughon, M.D., 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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November 11-14, 1978
Atlanta's World Congress Center

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____President's Dinner Dance—Sunday	$20.00 each	$_____
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POSTGRADUATE COURSES

_____	$____each	$_____
_____	$____each	$_____
_____	$____each	$_____
_____	$____each	$_____
	Total	$_____

REFUND DEADLINES: Postgraduate Courses--October 15, 1978
($20.00 Admin. fee charged on Postgraduate Course Refunds).
Dinner Dance and Luncheons—9:00 a.m. day of the event.

Tickets must be picked up in the SMA registration area—Friday, November 10, 12:00 noon-5:00 p.m., Peachtree Plaza Hotel; Saturday-Monday, November 11-13, 8:00 a.m.-5:00 p.m.; Tuesday, November 14, 8:00 a.m.-12:00 noon, Georgia World Congress Center.

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SATURDAY, NOVEMBER 11, 1978
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Georgia World Congress Center

NOVEMBER 11-14, 1978 — ATLANTA, GEORGIA

SATURDAY		SUNDAY		MONDAY		TUESDAY
AM	PM	AM	PM	AM	PM	AM
Dermatology	Dermatology	Dermatology—Clinical Session (Emory University)	Urology	Anesthesiology	Colon & Rectal Surgery	George Papanicolaou Memorial Seminar (Gyn., Ob., Path., & Rad.)
Gynecologic Oncology (Gynecology—Postgrad. course)	Gynecologic Oncology (Gynecology—Postgrad. course)			Otolaryngology	Allergy	
American Fertility Society (Postgrad. course) (Atlanta Hilton)	American Fertility Society (Postgrad. course) (Atlanta Hilton)	Anesthesiology	Dermatology Mini-courses (3): Acne, Warts, Aging Skin	Zola Cooper Clinicopathologic Seminar (Derm. & Path.)	Otolaryngology	Otolaryngology
		Neurology, Neurosurgery, & Psychiatry				
Liver Disease (Gastroenterology—Postgrad. course)	Liver Disease (Gastroenterology—Postgrad. course)	Gastroenterology	*Gastroenterology, Emergency Medicine, Radiology, & Surgery	Medicine & Georgia Society of Internal Medicine	Pediatrics	Allergy
Pathology	Evaluation of Blood Transfusion Complications (Pathology-Postgrad. course)	Family Practice	Orthopedic Surgery	Plastic Surgery	Plastic Surgery	Radiology & RSNA
Cardiology (Medicine—Postgrad. course)	Cardiology (Medicine—Postgrad. course)	Urology				
Care of the Multiple Injured Patient (Orthopedic Surgery—Postgrad. course)	Care of the Multiple Injured Patient (Orthopedic Surgery—Postgrad. course)	Orthopedic Surgery	Ophthalmology	Orthopedic Surgery	Orthopedic Surgery—Clinical Session	
		Maxillofacial Surgery (Plastic Surgery—Postgrad. course)				
Georgia Neurosurgical Society	Georgia Neurosurgical Society	Ophthalmology	Medical Otolaryngology: Current Concepts in the Treatment of Common Disorders (Otolaryngology—Postgrad. course)	Ophthalmology	Pediatric Dermatology (Postgrad. course)	
Cardiopulmonary Resuscitation (Postgrad. course)	Cardiopulmonary Resuscitation (Postgrad. course)	Emergency Medicine				
Radiology	Radiology	Radiology	Gynecology	Pediatrics	Radiology & RSNA	
Ophthalmology	Surgery	Surgery	Psychiatry	Neurology, Neurosurgery, & Psychiatry		
Hand Surgery (Plastic Surgery—Postgrad. course)	Hand Surgery (Plastic Surgery—Postgrad. course)	Chest Diseases	Society for Investigative Dermatology	Emergency Medicine	Obstetrics	
	Ophthalmology				Pathology	
*Neurology & Medicine	Head & Neck Surgery (Otolaryngology—Postgrad. course)	Altanta Society of Pathologists	Atlanta Society of Pathologists	Surgery	Surgery	
				Urology (Postgrad. course)	Urology (Postgrad. course)	
Family Practice	*Medicine & Georgia Thoracic Society	Southern Gynecological & Obstetrical Society	Chest Diseases	Dermatology for the Non-Dermatologist (Postgrad. course)	Dermatology for the Non-Dermatologist (Postgrad. course)	
Chest Diseases	Neurology					

*Joint session indicated with Section in charge of program listed first.
All sessions begin at 9:00 AM and 2:00 PM unless otherwise indicated.

1978 Scientific Assembly
Medical Association of Georgia
Southern Medical Association
World Congress Center, Atlanta, November 11-14

HOTEL	Single	Double	Twin	Suites	
				Parlor, One Bedroom	Parlor, Two Bedrooms
Hyatt Regency Atlanta 265 Peachtree Street, N.E.	$33.00- $47.00	$43.00- $57.00	$43.00- $57.00	—	$145.00- $350.00
Omni International Hotel One Omni International	$40.00- $55.00	$50.00- $65.00	$50.00- $65.00	$ 90.00- $185.00	—
Peachtree Plaza Hotel Peachtree at International Boulevard	$36.00- $49.00	$46.00- $59.00	$46.00- $59.00	$120.00- $180.00	$180.00- $260.00

SMA POSTGRADUATE COURSES
ATLANTA, GA.

Saturday, November 11, 1978

Course Number

1 **Gynecologic Oncology**—J. Max Austin, Jr., MD, Birmingham, Ala., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

2 **Update in Reproductive Endocrinology and Infertility (American Fertility Society)**—Charles B. Hammond, MD, Durham, N.C., Course Director, Fee: $100 (9:00 a.m.-5:00 p.m., Atlanta Hilton Hotel)

3 **Liver Disease**—John T. Galambos, MD, Atlanta, Ga., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

4 **Cardiology**—Arnoldo Fieodtin, MD, Atlanta, Ga., Course Director, Fee: $65 (9:00 a.m.-5:00 p.m.)

5 **Care of the Multiple Injured Patient**—Joseph A. Moylan, MD, Durham, N.C., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

6 **Problem Case Seminar on Common Hand Injuries: Basic and Advanced Techniques**—Ira M. Dushoff, Jacksonville, Fla., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

7 **Evaluation of Blood Transfusion Complications**—Ali A. Hossaini, MD, PhD, Richmond, Va., Course Director, Fee: $30 (2:00-5:00 p.m.)

8 **Head and Neck Surgery**—Fred M. S. McConnel, MD, Atlanta, Ga., Course Director, Fee: $30 (2:00-5:00 p.m.)

Sunday, November 12, 1978

9 **Maxillofacial Surgery**—Kenneth D. Salyer, MD, Dallas, Tex., Course Director, Fee: $30 (9:00 a.m.-12:00 noon)

10 **Acne**—Dan K. Chalker, MD, Augusta, Ga., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

Course Number

11 **Diagnosis and Clinical Management of Verrucae**—Beverly B. Sanders, Jr., MD, Macon, Ga., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

12 **Common Actinic Damage of the Skin**—Tom J. Meek, Jr., MD, Baton Rouge, La., Course Director, Fee: $15 (2:00-4:00 p.m.) Designed for the non-dermatologist. Mini-course, LIMITED TO 12.

13 **Medical Otolaryngology: Current Concepts in the Treatment of Common Disorders**—Robert L. Baldwin, MD, Birmingham, Ala., Course Director, Fee: $30 (2:00-5:00 p.m.)

Monday, November 13, 1978

14 **Pediatric Urology**—Michael P. Small, MD, Miami Lakes, Fla., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

15 **Dermatology for the Non-Dermatologist**—Franklin S. Glickman, MD, Brooklyn, N.Y., Course Director, Fee: $60 (9:00 a.m.-5:00 p.m.)

16 **Pediatric Dermatology**—Guinter Kahn, MD, North Miami Beach, Fla., Course Director, Fee: $40 (1:00-5:00 p.m.)

All courses fully accredited by the Council on Medical Education of the American Medical Association and are acceptable for hour-for-hour Category I credit toward the Physician's Recognition Award.

You may register for postgraduate courses by using the form in the front of the Preliminary Program which appears in the August issue of the *Journal*.

All courses will be held in the Georgia World Congress Center, unless otherwise designated.

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GEORGIA . . . . . Ralph L. Comerford, Director, 1980 Stanley Road, N.W., Kennesaw 30144
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JOURNAL
of the medical association of
georgia

MAG Annual Scientific Assembly

NOVEMBER 11-14, 1978 • GEORGIA WORLD CONGRESS CENTER • ATLANTA

MAG's 1978 Scientific Assembly will undoubtedly be the most comprehensive and well-attended ever. Since the Southern Medical Association is joining forces with the MAG this year, there will be many out-of-state attendees, and the new Georgia World Congress Center will provide a spacious and attractive setting. Guests will stay at one of three downtown hotels reserved for the Assembly — the Peachtree Plaza, Omni International, and Hyatt Regency. For the first time, there will be scientific programs and postgraduate courses in all specialties. Added features this year are a wide selection of contemporary educational activities for spouses and a full panoply of technical and scientific exhibits.

Scientific Programs

Scientific programs in the 23 major specialties will run from Saturday morning, November 11, to Tuesday noon, November 14. Following SMA's traditional format, each specialty section will feature a distinguished guest speaker and submitted papers by other speakers. The specialty societies in Georgia, as co-sponsors of the Assembly, have played an important role in the selection of speakers. Each society is represented by a program chairman who has worked closely with SMA's respective section secretary in designing the program.

Seventeen postgraduate courses will offer in-depth education in a variety of special clinical topics. To cover the expense of faculty, each course has a designated fee, and pre-registration is required on the form provided in this issue of the *Journal*.

MAG Luncheon

The MAG Luncheon and annual Calhoun Lecture will get the Scientific Assembly off to a good start on Saturday, November 11. Delivering the lecture will be C. H. William Ruhe, M.D., Senior Vice President of the AMA and for the last twenty years a leading architect of policy for American medical education. Dr. Ruhe's topic is "1984: Nightmare or Utopia for Medical Education?" All Assembly participants and spouses, especially MAG members, are invited and urged to attend. Tickets should be ordered on the pre-registration form.

Registration

Physicians planning to attend the Assembly should pre-register, using the detachable registration form found in this issue of the *Journal*. There will be NO registration fee for members of the MAG or the SMA. The fee for non-members is $20. No fee will be charged to program participants, nurses, or medical students, interns and resident/house staff officers who can identify themselves or who have a letter from their supervisor. Registration desks will be open in the Georgia World Congress Center Saturday-Monday, November 11-13, 8:00 a.m.-5:00 p.m., and Tuesday, November 14, 8:00 a.m.-12:00 noon. Those wishing to register early may do so at the Peachtree Plaza Hotel on Friday, November 10, 12:00 noon-5:00 p.m.

Hotel Reservations

Use the pre-registration form to make reservations at any of the three hotels reserved for the Assembly — the Omni International (next door to the World Congress Center), and Peachtree Plaza (headquarters hotel for the Assembly), and the Hyatt Regency on Peachtree Street.

CME Credits

As an organization accredited for continuing medical education, the Southern Medical Associa-

tion certifies that all scientific sessions and postgraduate courses meet the criteria for AMA Category 1 credit on a one-credit-per-hour basis. In addition, the entire program is acceptable for 77 Prescribed and 168 Elective hours by the American Academy of Family Physicians.

Spouses Program

A special effort has been made this year to offer spouses a variety of planned activities, including educational sessions on cosmetic surgery, cardiopulmonary resuscitation, finance for women, interior design, antiques, gardening, and body language. There will also be a "Creative Christmas Shopping" trip to some very special Atlanta stores. Complete details and registration information can be found elsewhere in this issue.

Special Events

Alumni reunions for a dozen medical schools in the Southeast will be held on Monday, November 13. There will be golf and tennis tournaments on the same day, in addition to the SMA President's Luncheon with Art Buchwald as guest speaker. The SMA President's Night Dinner Dance, featuring entertainment by Ferrante and Teicher, will begin at 7:30 p.m. on Sunday, November 12, at the Peachtree Plaza Hotel. All SMA members, MAG members, and guests are invited to a reception for SMA President Andrew F. Giesen Jr., M.D., on Saturday, November 11, 7:00-8:30 p.m. in the Peachtree Plaza.

Planning Committee

Members of the Planning Committee for the 1978 Scientific Assembly are: E. Napier Burson Jr., M.D., Chairman; C. Rex Teeslink, M.D.; Mark M. Lindsey, M.D.; LaMar S. McGinnis Jr., M.D.; A. Calhoun Witham, M.D.; Arthur J. Merrill Jr., M.D.; and Stephen L. Daniel, Ph.D., MAG Coordinator. Special thanks go to Edwin C. Evans, M.D., whose diligent work of liaison between the MAG and SMA has brought this first-ever combined Scientific Assembly to reality.

MAG PROGRAM CHAIRMEN

Allergy and Immunology Society of Georgia	Donald McLean, M.D.
Georgia Society of Anesthesiologists	D. C. Finlayson, M.D.
Georgia Thoracic Society	C. Neil Kelley, M.D.
Atlanta Dermatological Society	Chenault W. Hailey, M.D.
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American College of Physicians—Georgia	John M. McCoy, M.D.
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Georgia Neurological Society	John E. Lee, M.D. George R. Mushet, M.D.
Georgia Neurosurgical Society	Alan S. Fleischer, M.D. Floyd L. Haar, M.D.
Georgia State Obstetrical-Gynecological Society	William H. Kilpatrick, M.D.
Georgia Society of Ophthalmology	Edward Fineberg, M.D.
Georgia Orthopedic Society	Alfred Colquitt III, M.D.
Georgia Society of Otolaryngology	John Turner, M.D. Fred M. S. McConnel, M.D.
Georgia Association of Pathologists	John F. Nickerson, M.D.
Atlanta Society of Pathologists	B. C. Brown, M.D.
Georgia Chapter, American Academy of Pediatrics	Alexander F. Robertson III, M.D.
Georgia Society of Plastic Surgeons	Lovic W. Hobby, M.D.
Georgia Psychiatric Association	W. Theron McLarty, M.D.
Georgia Radiological Society	Stewart Roberts Jr., M.D.
Georgia Chapter, American College of Surgeons	LaMar S. McGinnis Jr., M.D.
Georgia Urological Association	Thomas J. Florence, M.D.

Preliminary Program

(Includes day-by-day schedule of scientific sessions and postgraduate courses, with highlights of each session. For more extensive program, including abstracts of presentations, see August 1978 issue of Southern Medical Journal *(copy sent to every Georgia physician). Final complete program available at the Assembly.* **Unless otherwise indicated, all sessions will be held in the Georgia World Congress Center, Atlanta.)**

SATURDAY MORNING, NOVEMBER 11

CHEST DISEASES
Co-sponsors: Georgia Thoracic Society
American College of Chest Physicians, Southern Chapter
"Symposium on Anaerobic Infections of the Lung," 9:00.

DERMATOLOGY
Co-sponsor: Atlanta Dermatological Society
Guest Speaker, Donald J. Birmingham, Detroit, MI, "Occupational Dermatology in Review — Old, New and Unusual," 9.00. Other presentations to follow.

FAMILY PRACTICE
Co-sponsor: Georgia Academy of Family Physicians
"Practical Approach to Medical Records." Guest Speaker, Jack Froom, Stony Brook, NY, "Classification of Health Problems," 9:20, and "The Problem-Oriented Medical Record," 10:40. Other presentations beginning at 9:00.

GASTROENTEROLOGY
Co-sponsor: American College of Gastroenterologists
Postgraduate course, "GI and Liver Diseases: Update on Management," 9:00, John T. Galambos, Atlanta, GA, Director.

GYNECOLOGY
Postgraduate course, "Update in Reproductive Endocrinology and Infertility," 9:00, Atlanta Hilton Hotel, Charles B. Hammond, Durham, NC, Director.

Postgraduate course, "Gynecologic Oncology for the Practicing Physician: Detection, Evaluation, Treatment and Follow-Up," 9:00, J. Max Austin Jr., Birmingham, AL, Director.

INTERNAL MEDICINE
Postgraduate course, "Cardiology," 9:00, Arnoldo Fiedotin, Atlanta, GA, Director.

Postgraduate course, "Cardiopulmonary Resuscitation: Basic Rescue Course," 9:00, Georgia Heart Association, Sponsor.

See also combined program under neurology.

NEUROLOGY, INTERNAL MEDICINE
Co-sponsor: Georgia Neurological Society
Guest Speakers, Redford B. Williams Jr., Durham, NC, "Diagnosis of Headache and the Use of Behavioral Approaches to Treatment of Headache," 9:00, and Fritz E. Dreifuss, Charlottesville, VA, "Current Status of the Treatment of Epilepsy," 10:30. Other presentations included.

NEUROSURGERY
Co-sponsor: Georgia Neurosurgical Society
"Advances in Neurodiagnostic Techniques." Guest Speaker, Irvin Kricheff, New York, NY, "Interpreting the Abnormal Head CT Scan," 9:15. Other presentations beginning at 9:00.

OPHTHALMOLOGY
Co-sponsor: Georgia Society of Ophthalmology
Full schedule of presentations, 9:00.

ORTHOPEDIC AND TRAUMATIC SURGERY
Postgraduate course, "Care of the Multiple Injured Patient," 9:00, Joseph A. Moylan, Durham, NC, Director.

PATHOLOGY
Co-sponsors: Georgia Association of Pathologists
Atlanta Society of Pathologists
"Seminar on Pearls in Anatomic Pathology," 9:00.

PLASTIC AND RECONSTRUCTIVE SURGERY
Postgraduate course, "Problem Case Seminar on Common Hand Injuries: Basic and Advanced Techniques," 9:00, Ira M. Dushoff, Jacksonville, FL, Director.

RADIOLOGY
Co-sponsor: Georgia Radiological Society
Full schedule of presentations, 9:00.

MAG LUNCHEON AND 1978 CALHOUN LECTURE

Saturday, November 11, 1978
12:00-1:30 p.m.

"1984: Nightmare or Utopia for Medical Education?"
—C. H. William Ruhe, M.D.
Senior Vice President,
American Medical Association



Dr. Ruhe has been for the past two decades one of the leading shapers of medical education in the United States. Continuing a 50-year tradition of outstanding Calhoun lecturers, Dr. Ruhe will predict some striking changes in the way tomorrow's physicians are trained and credentialed.

SATURDAY AFTERNOON

CHEST DISEASES
See combined program under internal medicine.

DERMATOLOGY
Co-sponsor: Atlanta Dermatological Society
Full schedule of presentations, 2:00.

GASTROENTEROLOGY
Co-sponsor: American College of Gastroenterology
Postgraduate course, "GI and Liver Diseases: Update on Management," continued, 2:00.

GYNECOLOGY
Postgraduate course, "Update in Reproductive Endocrinology and Infertility," continued, 2:15.

Postgraduate course, "Gynecologic Oncology for the Practicing Physician: Detection, Evaluation, Treatment and Follow-Up," continued, 1:30.

INTERNAL MEDICINE
Postgraduate course, "Cardiology," continued, 2:30, St. Joseph's Hospital.

Postgraduate course, "Cardiopulmonary Resuscitation: Basic Rescue Course," continued.

INTERNAL MEDICINE, CHEST DISEASES
Co-sponsors: Georgia Thoracic Society
American College of Physicians — Georgia
Georgia Society of Internal Medicine
"Symposium on Pulmonary Infections." Guest Speaker, Jay P. Sanford, Bethesda, MD, "Current Approach to Pneumonia in Normal and Compromise Host," 2:00. Other presentations to follow.

NEUROLOGY
Co-sponsor: Georgia Neurological Society
Guest Speaker, Fritz E. Dreifuss, Charlottesville, VA, 2:00.

Business Meeting, Georgia Neurological Society, 4:00.

NEUROSURGERY
Co-sponsor: Georgia Neurosurgical Society
"Neurosurgery by Needle." Guest Speaker, Irvin Kricheff, New York, NY, "Interventional Neuroradiology," 3:45. Other presentations beginning at 2:00.

OPHTHALMOLOGY
Co-sponsor: Georgia Society of Ophthalmology
Full schedule of presentations, 1:30.

ORTHOPEDIC AND TRAUMATIC SURGERY
Postgraduate course, "Care of the Multiple Injured Patient," continued, 2:00.

OTOLARYNGOLOGY
Postgraduate course, "Head and Neck Surgery," 2:00, Fred M. S. McConnel, Atlanta, GA, Director.

PATHOLOGY
Postgraduate course, "Evaluation of Blood Transfusion Complications," 2:00, Ali A. Hossaini, Richmond, VA, Director.

PLASTIC AND RECONSTRUCTIVE SURGERY
Postgraduate course, "Problem Case Seminar on Common Hand Injuries: Basic and Advanced Techniques," continued.

RADIOLOGY
Co-sponsor: Georgia Radiological Society
Guest Speaker, Manuel Viamonte Jr., Miami, FL, "Alogarithmic Pathways in Mediastinal Tumors," 2:30, and "Thoracic CT Scanning (Pulmonary and Mediastinal)," 3:30. Other presentations to follow.

SURGERY
Co-sponsor: Georgia Chapter, American College of Surgeons
Full schedule of presentations, 2:00.

SUNDAY MORNING, NOVEMBER 12

ANESTHESIOLOGY
Co-sponsor: Georgia Society of Anesthesiologists
Guest Speaker, John Downs, Gainesville, FL, "Current Concepts in Respiratory Care," 11:10. Other presentations beginning at 9:00.

CHEST DISEASES
Co-sponsors: Georgia Thoracic Society
American College of Chest Physicians, Southern Chapter
Guest Speaker, Joseph M. Civetta, Miami, FL, "Adult Respiratory Distress Syndrome," 11:00. Other presentations beginning at 9:00.

DERMATOLOGY
Co-sponsor: Atlanta Dermatological Society
Clinical Session, 9:00, Emory University Clinic.

EMERGENCY MEDICINE
Co-sponsor: Georgia Chapter, American College of Emergency Physicians
Business Meeting, Georgia Chapter, American College of Emergency Physicians, 10:00.

FAMILY PRACTICE
Co-sponsor: Georgia Academy of Family Physicians
Full schedule of presentations, 9:00.

GASTROENTEROLOGY
Co-sponsor: Georgia Gastroenterologic Society
Guest Speaker, Eugene R. Schiff, Miami, FL, "Hepatitis: Status and Prospects," 11:00. Other presentations beginning at 9:00.

GYNECOLOGY, OBSTETRICS
Co-sponsor: Southern Gynecological and Obstetrical Society
36th Annual Meeting, 9:00.

NEUROLOGY, NEUROSURGERY, PSYCHIATRY
"Psychoses and Neuroses: Biochemical Basis and Treatment." Guest Speaker, H. Thomas Ballantine Jr., Boston, MA, "The Role of Cingulotomy in the Treatment of Psychiatric Illness: Indications, Reservations, Expectations," 9:00. Other presentations to follow.

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NEUROSURGERY
See *combined program under neurology.*

OBSTETRICS
See *combined program under gynecology.*

OPHTHALMOLOGY
Co-sponsor: Georgia Society of Ophthalmology
Guest Speaker, Arthur H. Keeney, Louisville, KY, "Protection of the Eye from Ionizing Radiation: Factors in Cataractogenesis and Neovascularization," 10:05. Other presentations beginning at 9:00.

ORTHOPEDIC AND TRAUMATIC SURGERY
Co-sponsor: Georgia Orthopedic Society
Guest Speaker: C. McCollister Evarts, Rochester, NY, "Thromboembolic Disease Update," 11:30. Other presentations beginning at 9:00.

PATHOLOGY
Co-sponsor: Atlanta Society of Pathologists
Annual Slide Seminar, "Pathology of the Gastrointestinal Tract," 9:00, John H. Yardley and Theodore M. Bayless, Baltimore, MD, Prelectors.

PLASTIC AND RECONSTRUCTIVE SURGERY
Postgraduate course, "Treatment of Maxillofacial Injuries," 9:00, Kenneth E. Salyer, Dallas, TX, Director.

PSYCHIATRY
See *combined program under neurology.*

RADIOLOGY
Co-sponsor: Georgia Radiological Society
Guest Speaker, Manuel Viamonte Jr., Miami, FL, "Dermatoradiological Syndromes," 9:00, and "Radiology of Visceral Fat," 10:30. Other presentations to follow.

SURGERY
Co-sponsor: Georgia Chapter, American College of Surgeons
Guest Speaker, C. Rollins Hanlon, Chicago, IL, "Current Role of the American College of Surgeons in Surgical Practice," 10:05. Other presentations beginning at 9:00.

UROLOGY
Co-sponsor: Georgia Urological Association
Guest Speaker, William J. Staubitz, Buffalo, NY, "Surgical Management of Germinal Cell Tumors of Testis," 9:00, and "Therapy of Stromal Cell Tumors of the Testis and Paratesticular Tumors," 11:05. Other presentations included.

SUNDAY AFTERNOON

CHEST DISEASES
Co-sponsors: Georgia Thoracic Society American College of Chest Physicians, Southern Chapter
Full schedule of presentations, 2:00.

DERMATOLOGY
Postgraduate mini-course, "Acne," 2:00, Dan K. Chalker, Augusta, GA, Director.

Postgraduate mini-course, "Diagnosis and Clinical Management of Verrucae," 2:00, Beverly B. Sanders, Macon, GA, Director.

Postgraduate mini-course, "Common Actinic Damage of the Skin," 2:00, Tom J. Meek Jr., Baton Rouge, LA, Director.

Co-sponsor: Society for Investigative Dermatology
6th Annual Meeting, 1:00, Hyatt Regency Hotel. Guest Speaker, Andre J. Nahmias, Atlanta, GA.

EMERGENCY MEDICINE
See *combined program under gastroenterology.*

GASTROENTEROLOGY, EMERGENCY MEDICINE, RADIOLOGY, SURGERY
Co-sponsor: Georgia Gastroenterologic Society
"GI and Liver Disease: Emergencies," 2:00.

GYNECOLOGY
Co-sponsor: Georgia State Obstetrical and Gynecological Society
Guest Speaker, Kamran S. Moghissi, Detroit, MI, 3:00. Other presentations beginning at 2:00.

OPHTHALMOLOGY
Co-sponsor: Georgia Society of Ophthalmology
"Symposium on Intraocular Lenses," 1:00.

ORTHOPEDIC AND TRAUMATIC SURGERY
Co-sponsor: Georgia Orthopedic Society
"Residents' Competition," full schedule of scientific presentations, 2:00.

OTOLARYNGOLOGY
Postgraduate course, "Medical Otolaryngology: Current Concepts in the Treatment of Common Disorders," 2:00, Robert L. Baldwin, Birmingham, AL, Director.

PATHOLOGY
Co-sponsor: Atlanta Society of Pathologists
Annual Slide Seminar, "Pathology of the Gastrointestinal Tract," continued.

PSYCHIATRY
Co-sponsor: Georgia Psychiatric Association
"The Professional Marriage," 1:30.

RADIOLOGY
See *combined program under gastroenterology.*

SURGERY
See *combined program under gastroenterology.*

UROLOGY
Co-sponsor: Georgia Urological Association
Full schedule of presentations, 1:30.

MONDAY MORNING, NOVEMBER 13

ANESTHESIOLOGY
Co-sponsor: Georgia Society of Anesthesiologists
Full schedule of presentations, 9:00.

DERMATOLOGY
Postgraduate course, "Dermatology for the Non-Dermatologist," 9:00, Franklin S. Glickman, Brooklyn, NY, Director.

DERMATOLOGY, PATHOLOGY
Co-sponsor: Atlanta Dermatological Society
"Zola Cooper Clinicopathologic Seminar," 9:00.

EMERGENCY MEDICINE
Co-sponsor: Georgia Chapter, American College of Emergency Physicians
Guest Speaker, James E. George, Woodbury, NJ, "Law and Emergency Medicine," 9:00.

INTERNAL MEDICINE
Co-sponsor: Georgia Society of Internal Medicine
Full schedule of presentations, 9:00.

NEUROLOGY, NEUROSURGERY, PSYCHIATRY
"Stroke Syndromes and Surgical Treatment," 9:00.

NEUROSURGERY
See combined program under neurology.

OPHTHALMOLOGY
Co-sponsor: Georgia Society of Ophthalmology
Guest Speaker, Arthur H. Keeney, Louisville, KY, "Principles and Mechanisms in Judgment Concerning Intraocular Lenses," 10:45. Other presentations beginning at 9:00.

ORTHOPEDIC AND TRAUMATIC SURGERY
Co-sponsor: Georgia Orthopedic Society
Guest Speaker, C. McCollister Evarts, Rochester, NY, "Surface Replacement Hip Arthroplasty," 10:00. Other presentations beginning at 9:00.

OTOLARYNGOLOGY
Co-sponsor: Georgia Society of Otolaryngology
Full schedule of presentations, 9:00.

PATHOLOGY
See combined program under dermatology.

PEDIATRICS
Co-sponsor: Georgia Chapter, American Academy of Pediatrics
"Common Problems in Pediatrics," 9:00.

PLASTIC AND RECONSTRUCTIVE SURGERY
Co-sponsor: Georgia Society of Plastic Surgeons
Full schedule of presentations, 9:00.

PSYCHIATRY
See combined program under neurology.

SURGERY
Co-sponsor: Georgia Chapter, American College of Surgeons
Guest Speaker, James D. Hardy, Jackson, MS, "Abdominal Aortic Aneurysms," 10:00. Other presentations beginning at 9:00.

UROLOGY
Postgraduate course, "Pediatric Urology," 9:00, Michael P. Small, Miami Lakes, FL, Director.

MONDAY AFTERNOON

ALLERGY
Co-sponsor: Allergy and Immunology Society of Georgia
Guest Speaker, Oscar L. Frick, San Francisco, CA, 2:00. Other presentations to follow.

COLON AND RECTAL SURGERY
Guest Speaker, Alejandro F. Castro, Rockville, MD, "The Reappraisal of the Problem of Polyps of the Colon." Other presentations included.

DERMATOLOGY
Postgraduate course, "Pediatric Dermatology," 1:00, Guinter Kahn, North Miami Beach, FL, Director.

Postgraduate course, "Dermatology for the Non-Dermatologist," continued.

DERMATOLOGY, PATHOLOGY
Co-sponsor: Atlanta Dermatological Society
Zola Cooper Clinicopathologic Seminar, continued, 2:00.

OBSTETRICS
Co-sponsor: Georgia State Obstetrical-Gynecological Society
Guest Speaker, Richard H. Schwarz, Brooklyn, NY, "The Use of Antibiotics in Pregnancy," 4:00. Other presentations beginning at 2:00.

ORTHOPEDIC AND TRAUMATIC SURGERY
Co-sponsor: Georgia Orthopedic Society
"Clinical Session," 2:00, Emory University, Thomas E. Whitesides Jr., Atlanta, GA, presiding.

OTOLARYNGOLOGY
Co-sponsor: Georgia Society of Otolaryngology
Guest Speaker, Beverly W. Armstrong, Charlotte, NC, 1:40. Other presentations beginning at 1:30.

PATHOLOGY
Co-sponsors: Georgia Association of Pathologists
Atlanta Society of Pathologists
Guest Speaker, Henry J. Norris, Washington, D.C., "The Endometrial Carcinoma Pandemic," 4:15. Other presentations beginning at 2:00.

See also combined program under dermatology.

PEDIATRICS
Co-sponsor: Georgia Chapter, American Academy of Pediatrics

Guest Speaker, J. Gordon Millichap, Chicago, IL, "The Diagnosis and Treatment of the First Seizure," 1:30, and "Hyperkinesis," 3:00.

PLASTIC AND RECONSTRUCTIVE SURGERY
Co-sponsor: Georgia Society of Plastic Surgeons
Guest Speaker, Salvador Castanares, Los Angeles, CA, "Complications, Pitfalls and Techniques of Rhytidectomy," 1:15. Other presentations to follow.

RADIOLOGY
Co-sponsors: Georgia Radiological Society
Radiological Society of North America
Refresher Course #1, "Biliary Tract I: Oral and Intravenous Evaluation of the Liver, Gallbladder and Bile Ducts," 2:00, Robert N. Berk, San Diego, CA, Director. Other presentations to follow.

SURGERY
Co-sponsor: Georgia Chapter, American College of Surgeons
Full schedule of presentations, 2:00.

UROLOGY
Postgraduate course, "Pediatric Urology," continued.

TUESDAY MORNING, NOVEMBER 14

ALLERGY
Co-sponsor: Allergy and Immunology Society of Georgia
Full schedule of presentations, 9:00.

GYNECOLOGY, OBSTETRICS, PATHOLOGY, RADIOLOGY
Co-sponsor: Georgia State Obstetrical-Gynecological Society
"George Papanicolaou Memorial Seminar in Gynecologic Pathology," 9:00.

OBSTETRICS
See combined program under gynecology.

OTOLARYNGOLOGY
Co-sponsor: Georgia Society of Otolaryngology
Full schedule of presentations, 9:00.

PATHOLOGY
See combined program under gynecology.

RADIOLOGY
Co-sponsors: Georgia Radiological Society
Radiological Society of North America
Refresher Course #2, "Biliary Tract Radiology II: Direct Cholangiography," 9:00. Other presentations to follow.

RADIOLOGY
See combined program under gynecology.

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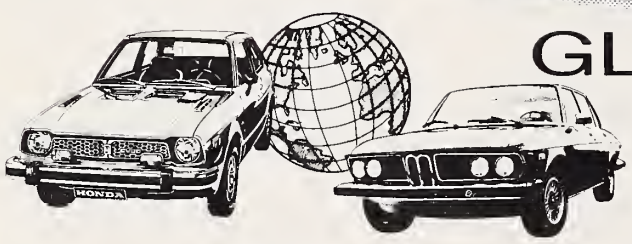
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Spouse Program

MAG-SMA

1978 SCIENTIFIC ASSEMBLY

Welcome to Atlanta for the 72nd Annual Scientific Assembly of the Southern Medical Association! This year's meeting, combined with the Medical Association of Georgia, will be quite exciting. An innovation this year is a schedule of activities for spouses, in addition to the usual social events. We hope you will take the time now to read through this program and decide which events interest you, and mail the registration card with a check to the proper address before November 1.

The SMA Registration Desks will be in the Exhibit Hall at the Georgia World Congress Center. The area will be open from 8 to 5 Saturday through Monday, and 8 to 12 noon on Tuesday.

The SMA Auxiliary's Southern Hospitality Room and Registration Desks will be at the Omni International Hotel. The area will be open Saturday from 10 to 5, Sunday from 8:30 to 3, and Monday and Tuesday from 8:30 to 12 noon. Hostesses will be on hand, eager to help in any way to make your stay in Atlanta a pleasant one. Plan to stop by frequently for relaxation and conversation!

For ticket information for the SMA Auxiliary breakfasts, contact Mrs. David C. Thibodeaux, 588 Heyward Circle, NW, Marietta, Georgia 30064.

SATURDAY, NOVEMBER 11, 1978

Female? Fantastic!
9:00 a.m.-10:00 a.m.
Georgia World Congress Center
(Ticket)

Judy Ford Stokes defines success as being the best YOU can be, whether you are an emerging career woman, homemaker or a combination of both. Nationally known as a captivating speaker, Mrs. Stokes is one of the Ten Outstanding Young People in Atlanta, Vice-President of the Atlanta Area UNICEF board, and the Editor of *Atlanta Cooks for Company*.

Cardiopulmonary Resuscitation—A Life Saver
9:00 a.m.-12:00 noon
Georgia World Congress Center
(Ticket)

If someone's heart stopped beating or he stopped breathing, would you know what to do to help? In this three-hour course you can learn to use life-saving measures in emergency situations.

Southern Living Gardening Demonstration
2:00 p.m.-3:30 p.m.
Georgia World Congress Center
(Ticket)

John Floyd, Senior Horticulturist with *Southern Living* magazine, and Carolyn D. Tynes, partner in Garden Designs in Birmingham, Alabama, will present a demonstration and discussion on popular woody ornamental plants used both indoors and outdoors. Dr. Floyd will discuss the correct care and uses of various ornamental plants in landscaping, and Mrs. Tynes will demonstrate their use in the popular foliage arrangements that grace so many homes today.

Did You Really Mean to Say That?
2:00 p.m.-4:00 p.m.
Georgia World Congress Center
(Ticket)

"Did You Really Mean to Say That?" or the Science of Body Language, is a slide and game program. In an entertaining way, Dr. Harold Davis will show you how to understand what other people are saying to you by the way they hold their bodies, sit in chairs, gesture, etc. Dr. Davis is Chairman of the Department of Journalism at Georgia State University, and has been a Washington correspondent and the city editor of the *Atlanta Journal*.

SUNDAY, NOVEMBER 12, 1978

Cosmetic Surgery
2:00 p.m.-4:00 p.m.
Georgia World Congress Center
(Ticket)

Who's to say that beauty can't be improved with a few nips and tucks in just the right places! Dr. Salvador Castanares, a leading plastic surgeon in Los Angeles, will tell what plastic surgery is all about and discuss techniques involved. A panel of experts will be available for in-depth questioning. Here's your chance to get those answers for "all your friends!"

Finance for Women
2:00 p.m.-3:30 p.m.

Georgia World Congress Center
(Ticket)

If you've ever wished you could get several financial experts together at one time, this is your afternoon for excitement! Join the group — and discover the importance of establishing credit in your own name. The Business and Professional Women of Atlanta will sponsor a panel discussion on estate planning, with emphasis on information important to the physician's wife. Your questions are encouraged.

Professional Approach to Interior Design

2:00 p.m.-3:30 p.m.
Georgia World Congress Center
(Ticket)

Hear an expert in interior design explain the principles of floor plans, furniture arrangements, lighting and finishing details. Susan Katz, nationally featured in magazines such as *House Beautiful* and *Better Homes and Gardens,* will use acetate overlays to show the steps to take in planning beautiful rooms. Your answers to a questionnaire will give Ms. Katz the opportunity to help you in special problem areas.

SMA President's Night Dinner Dance

6:30 p.m. Hospitality Hour
7:30 p.m.-12:00 midnight
Peachtree Plaza Hotel
(Tickets may be obtained at the SMA Registration Desks prior to noon Sunday)

Don't miss the President's Night Dinner Dance! You will feast upon a tempting array of food in sumptuous surroundings, while listening to the diverse talents of the dynamic piano duo, Ferrante and Teicher. Dancing for all will complete this gala event. Plan to attend, wine and dine with your friends, and enjoy a spectacular evening!

MONDAY, NOVEMBER 13, 1978

Investment Quality Antiques
2:00 p.m.-3:30 p.m.
Rich's, Downtown
(Ticket)

How do you recognize quality antiques? Are certain antiques better investments than others? A fascinating slide presentation on Old English antiques will be shown at the downtown Rich's. Mr. Howe, an authority on fine furniture and a buyer for Rich's, will answer these and many other questions concerning quality antiques and their value. After the presentation, a shopper's paradise awaits you — whether you're searching for something precious or something with "pizazz," Rich's has everything! Buses will return at 5:00.

Creative Christmas Shopping
2:00 p.m.-5:30 p.m.
(Ticket)

A fun-filled afternoon of creative Christmas shopping awaits you when you board the bus today! You will be taken on a shopping spree beginning with the Textile Mill Store, where you may purchase name-brand towels, sheets, bedspreads and decorative pillows at near wholesale prices. In the same center is a beautiful gift store, and a doll house and antique store. The second stop will be Loehmann's, where you will find today's designer and moderately priced clothes at ½ price! There is a discount men's clothing store and a famous label shoe store nearby. Andrews Square is next — a quaint little boutique and specialty shop area offering an art gallery, a gourmet cooking shop, and French designer clothes. Sherry will be served on the tour. An optional stop will be made at Phipps Plaza and Lenox Square for those who wish to leave the tour early.

Precious Jewelry Show
2:00 p.m.-3:30 p.m.
Neiman-Marcus, Lenox Square
(Ticket)

A rare treat is in store for Monday afternoon — a precious jewelry show at Neiman-Marcus in Lenox Square. Current important pieces including estate jewelry will be on display, and Mr. Bill Sharp will use models from the audience as he talks about the collection. He will give suggestions on the selection of jewelry to complement various fashions, and is well qualified to answer any questions you might have about fine jewelry. Afterward, you will be free to shop throughout Neiman-Marcus and the fabulous Lenox Square. Buses will return at 5:00.

TUESDAY, NOVEMBER 14, 1978

Private Home Tour
11:00 a.m.-3:30 p.m.
(Ticket)

A unique opportunity for you to visit several of Atlanta's finest homes — normally closed to all but family and friends. You will see the Maynard Smith home, contemporary in style and traditional in furnishings, and Mrs. Smith's extraordinary collection of Cybis Porcelain. The second house will be a fabulous restored Victorian home in Inman Park, where the President of Atlanta's Victorian Society, Mr. Jim Whitnal, will speak about the architecture and resurgence of the Victorian period. The last home will be an antique lover's delight! Lunch will be served at the beautiful Abbey Restaurant.

CME and Human Values

How would you as a doctor decide in the case of Chad Green, the three-year-old leukemic boy whose parents refused to have him continue chemotherapy because it was too painful and disruptive of family life?

If two patients needed regular hemodialysis in order to survive, and there were only sufficient resources to support one on the machine, how would you decide which one?

These are examples of the hard questions addressed in a series of six evening seminars on "Human Values in Health Care," held this July at Morehouse College in Atlanta. The free seminars, co-sponsored by Emory University School of Medicine, featured an outstanding faculty of seven physicians and six "humanists" (the physicians appeared to be humanists too). Topics treated were informed consent and patient autonomy, genetic disease, the definition of health and illness, death and dying, and the allocation of medical resources.

Each of the seminars attracted an audience of between 30 and 70 people, including several physicians. One internist made all of the sessions, carefully counting his Category 1 credits for the Physician's Recognition Award and relating to me that he both enjoyed and profited from the meetings. A number of medical students, including some from Morehouse's inaugural class, enlivened the discussion. Teachers, health care professionals, community leaders, and just plain citizens all contributed their views.

During the past year the MAG's Committee on Medicine and Human Values worked on new "death with dignity" legislation for Georgia and studied the rise of the hospice movement as a humane approach to care for the terminally ill. The Committee considered organizing and sponsoring a CME program on some subject in which the practice of medicine intersects with human values, but it decided not to take the risk of having a poor turnout from MAG members. Perhaps the decision not to plan such a program was a bit hasty and uninformed. If so, the MAG invites the suggestions of MAG members for CME programs on the human aspects of medical practice. You may write to the Chairman of the Committee on Medicine and Human Values, Ronald M. Hudson, M.D., or to the Director of the Division of Education, Stephen L. Daniel, Ph.D., c/o MAG Headquarters. — **S.L.D.**

Please complete this form and forward with your check to the address shown. Be sure that you have:

- Indicated the number of tickets required for EACH activity
- Made your check payable to Southern Medical Association
- Completed the information on name and address so that confirmation can be sent to you

DEADLINE FOR ADVANCE TICKET SALES PRIOR TO THE MEETING IS NOVEMBER 1. No orders will be processed following that time.

Buses will depart as noted on tickets.

All prices are quoted for both adults and children at the same rates. No refunds after November 1.

For ticket information for the SMA Auxiliary breakfasts, contact Mrs. David C. Thibodeaux, 588 Heyward Circle, NW, Marietta, Georgia 30064.

1978 MAG-SMA SCIENTIFIC ASSEMBLY
SPOUSE ACTIVITIES

Indicate EXACT number of tickets requested in the spaces below:

SATURDAY, NOVEMBER 11, 1978

# of Tickets		
——	A. Female? Fantastic!	$ 5.00 per person
——	B. CPR	$ 5.00 per person
——	C. Southern Living Gardening	$ 5.00 per person
——	D. Body Language	$ 5.00 per person

SUNDAY, NOVEMBER 12, 1978

——	E. Cosmetic Surgery	$ 5.00 per person
——	F. Finance for Women	$ 5.00 per person
——	G. Interior Design	$ 5.00 per person

MONDAY, NOVEMBER 13, 1978

——	H. Investment Quality Antiques	$ 5.00 per person
——	I. Creative Christmas Shopping	$ 6.50 per person
——	J. Precious Jewelry Show	$ 5.00 per person

TUESDAY, NOVEMBER 14, 1978

——	K. Private Home Tour	$10.50 per person

Enclosed is my check in the amount of $_____. Please make all checks payable to Southern Medical Association.

Name _____

Address _____

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City _____ State _____ Zip _____

Send all checks with this registration form to:

Southern Medical Association
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stepping down estrogen levels to 50 mcg?



Do you have patients currently taking oral contraceptives containing 100 mcg of estrogen for contraception? A switch to a 50 mcg product may be desirable.§

Prospective and retrospective studies indicate a relationship between estrogen doses and serious adverse side effects. "...preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism..."† The incidence of these side effects decreases as the dosage of estrogen decreases to 50 mcg, as demonstrated in British studies.†

†See Prescribing Information.

a step in the right direction

Ortho-Novum 1/50

TRADEMARK

21 and 28-day regimens

Each yellow tablet contains 1 mg norethindrone and 0.05 mg mestranol.
Each green tablet in the 28-day regimen contains inert ingredients.

§Serious as well as minor side effects have been reported with the use of oral contraceptives. These include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See the complete Prescribing Information for this product, a summary of which is on the next page.

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OJ 1291

ORTHO-NOVUM* Tablets

IMPORTANT NOTE—This information is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summary was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information and patient information before prescribing the product.

INDICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literature for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnancies Per 100 Women-Years. IUD, less than 1-6; Diaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-80. **DOSE-RELATED RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen.

CONTRAINDICATIONS: Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenome, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 100,000 users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American study of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.

MYOCARDIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 100,000 women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Dose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 50-80 mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been performed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,000 (ages 15-34—5/100,000; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 10-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 50 percent.) The mortality associated with oral contraceptive use in nonsmokers over 40 is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS AND OTHER PREDISPOSING CONDITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 30	30-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	0	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	0	C,0	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	0—Use associated with low risk.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIONS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Discontinue oral contraceptive medication if there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were first given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception.

Figure 1. Estimated annual number of deaths associated with control of fertility and no control per 100,000 nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUDs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	0.3	0.4	0.4	0.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEDIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent of becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or five years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPID METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may interfere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use of oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being performed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 10. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT: (See Patient Package Insert). DRUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINDICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users of oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVERDOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established, therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt, discontinue the preparation until adequate control by other antiinfectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, secondary infection, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptions, maceration of the skin, and hypopigmentation. Contact sensitivity to a particular dressing material or adhesive may occur occasionally. Ototoxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also available in jars of 120 g. (4 oz.) for hospital or institutional use only.

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Health Care Spending in America

J. RHODES HAVERTY, M.D., *Atlanta**

THIS MAY BE A DIFFERENT kind of commencement speech than one usually hears. But this particular audience is peculiarly appropriate to have this issue highlighted. I intend to discuss health care spending in America today.

I feel there are two general themes that need attention: the first is that too much is being spent for what this country can afford, and the second is the inappropriateness of what we *are* spending. I intend to recite some facts and some opinions by various leaders and writers about the subject and to leave you with some thoughts to which each of you must react.

How Much *Are* We Spending?

In 1929, our total national spending on health care was $3.5 billion dollars; by 1950, the total had climbed to $12 billion; by 1970, to $69 billion, and this year it is expected to approach $200 billion. Hospital costs have been going up by more than 15 percent annually in recent years. The cost of an average day in a hospital now is close to $200. In 1976, expenditures on health care averaged about $638 per person per year.[5]

Health expenditures in the United States began to exceed our defense costs in 1971, when both were about $85 billion. By 1973, health expenditures approached $105 billion, while defense spending was about $80 billion, and the difference is still increasing.[1]

In a recent *JAMA* article, Dr. David Rogers stated, "The problem of the cost of care that triggered public concern about health and medical services remains very much with us, and the 'crisis' continues. Since the 1960s, escalating health care costs have been one of the major problems facing the nation. They remain so. During the last decade we spent more for health and medical care than we did during the entire previous 35 years. With health expenditures for a family rising from $567 in 1960 to $2,188 in 1975, this has proved a steadily escalating burden for most American families. If they cannot be contained, costs may prove to be the Achilles' heel of this country's arrangements for health services."[1]

Dr. Alain C. Enthoven recently stated in an article in the *New England Journal of Medicine*, "Headlines will soon appear proclaiming the latest round of health-care cost increases. The nation's health care spending exceeded $160 billion in 1977 — four times the 1965 amount. Congress will consider cost-control measures with increasing urgency."[2]

The author continues, "Real per-capita spending on health care (i.e., net of general inflation) increased 79 percent from 1965 to 1976; it increased 74 percent on physicians' services and 110 percent on hospital care. Costs of medical care are straining public finances at every level of government and are forcing cutbacks in services to the needy. *Public*-sector spending rose from 25 percent of the total in 1965, to 42 percent of the total in 1976. In 1975, the increase in medical costs forced Massachusetts to stop paying for the health care of the general-relief population, throwing the burden on local government. From 1968 to 1976, Medi-Cal costs in Los Angeles County increased from 24 to 42 percent of property tax revenue."[2]

So much for general trends. Now for some comments on

Extraordinary Spending

In 1970, a six-year-old was bitten by a rapid bat. In an editorial, the executive director of Grady Memorial Hospital in Atlanta stated that, "The story goes on to detail an incredible struggle by three physicians, including one who flew in specially from the Center for Disease Control, to ensure that everything — absolutely everything — that could be done to save little Matt's life would be done. 'The bill was enormous, but my husband was working for General Electric. That paid for most of it,' the article quotes Matt's mother as saying."[3]

Several articles in the news media during this past year have commented on the now five-year-old boy was was born with no immune mechanisms. According to the publicized accounts, it has cost roughly $200,000 a year to keep this child alive and healthy in a germ-free environment.

Recently on national television, a home for autistic children was featured. During that program, it was commented that it took $16,000 per child per year in an attempt to treat such individuals so that they might be able

* Dean, College of Allied Health Sciences, Georgia State University, University Plaza, Atlanta, Ga. 30303. This is the text of a speech made by Dr. Haverty to the 1978 graduating class of the University of Mississippi School of Medicine.

to exist without harm to themselves or others in a normal society.

It has been said that by the end of 1978, more than $2 billion will have been spent on people with chronic renal problems in the United States. A recent article in *The Atlanta Constitution* featured this problem, and stated that Congressmen and government officials have become increasingly concerned over a federal program that is sustaining the lives of about 40,000 people who are suffering from kidney disease.[4]

The article stated that, "In Britain, meanwhile, several thousand people suffering from the same sorts of disease have died each year recently because the government refused to give the socialized health system the funds necessary to pay for the medical technology needed to prevent them from dying.

"Some of the legislators and administrators in the U.S. who supported the kidney dialysis program for humanitarian reasons when it was first enacted six years ago now are having second thoughts about it because the costs are becoming enormous."

The article continues, "It is now likely that the federal government will be paying $1 billion in the next fiscal year to keep sufferers of incurable kidney disease alive, an amount that is from three to six times the cost that was anticipated when Congress enacted the program in 1972.

"The key point at issue in the dispute over the costs of kidney dialysis is where the procedure should be performed — at home, at an average yearly cost of $8,000 to $12,000, or at an institution, where costs range from $15,000 to $30,000 a year. It is interesting that about 90 percent of Americans undergo dialysis at an institution, whereas in Canada the ratio is 40 percent, and in Britain it is 35 percent."[4]

Why Are We Spending So Much?

Let us look at that question.

The Secretary of HEW has estimated recently that there are about 100,000 excess hospital beds in the country, costing about $2 billion a year to maintain, without helping a single patient.

A recent study of the Veterans Administration system concluded, "These data provide additional evidence that many more VA hospital beds are being operated than are required to meet the needs of veterans. . . . The VA has installed many expensive specialized medical facilities that, in many hospitals, are used at rates far below their capacity."[2]

"Since we health providers are more knowledgeable than others regarding the appropriateness of health care and its settings, it is our responsibility to point the way, and to insist that the bitter pill be swallowed."

Another recent article in an Atlanta newspaper stated that each additional doctor entering the market created from $150,000 to $350,000 in health care spending annually. The number of doctors is growing more than three times faster than the population.[5]

The rising expectation of people as to what constitutes a condition requiring medical attention now means that minor aches and pains that once were accepted as part of life are now taken to the doctor. In addition, accounts of medical progress, both real and hoped for, have created the false view that there is something doctors can do for every disease or injury that natural healing processes cannot. Some doctors, for example, report that patients with ordinary headaches no longer are settling for aspirin. They have heard of "CT scanners" and have come in demanding to be examined with this extremely expensive device.[5]

Largely because of Medicare, Medicaid, and private insurors, there has been a tremendous increase in access to and use of health facilities. In 1931, the average American visited a physician 2.6 times; this had risen to 4.5 times in 1964, and to 5.1 times in 1975.[1]

People now see doctors at the staggering rate of 2.9 million visits per day. The U.S. has more physicians per capita than Canada, England, Sweden, or virtually any other Western European country except West Germany.

The AMA considers that the proximate causes of escalating medical costs are largely abstract, including: strong inflationary pressures in general; the remarkable improvements in clinical and technological resources; the expansion of benefits and of eligible recipient populations under government health programs; the increased demands for services because of these advances; longer average life spans; the requirement of extraordinary amounts of care for chronic illnesses, and other factors such as soaring professional liability insurance costs for hospitals and physicians, which are passed on eventually to the patient.

The late Dr. Robert Perry, 1977 President of the Medical Association of Georgia, summed up some of the reasons why we are spending so much in a statement given before the Department of HEW in October, 1977. He said, "The art and science of medicine has come a long way since the days of our grandfathers when doctors covered the countryside in buggies and the instruments of their medical expertise fitted into a little black bag. Today we live in a period of seemingly never-ending discovery, where medical miracles are taken for granted and the level of expectancy on the part of our patients is exceedingly high. Rebuilding arthritic hips, performing kidney transplants, open heart surgery, and a host of sophisticated procedures have become commonplace. Current life expectancy has almost doubled in this century and we are making real progress toward conquering our number one killer — heart disease."

Dr. Perry concluded by saying, "However, the simple truth of the matter is that high quality medical care necessarily involves some high costs."[6]

Another quote from the article by Dr. Enthoven states, "There are good reasons for much of the increase in health spending: growth in public and private insurance coverage brought access to many who previously did not have it, especially the aged and the poor; advances in technology increased the power of medicine to prolong life and enhance its quality; the population aged; the health-care system took on new assignments (e.g., in mental health, alcohol and drug abuse); the pay of health-care workers was brought up to the level of other industries; and rising incomes and expectations increased consumer demand for health-care services. Present concern with the growth in

spending should not mislead one into thinking it is all bad.

"However," Dr. Enthoven continues, "the increase has far exceeded what could be justified on these grounds, especially in recent years. Hospital charges and physician fees rose faster than consumer prices in general. Health workers' pay overshot equality with other industries. There is great inefficiency (e.g., duplication of costly under-utilized facilities). In California alone in 1975, cardiac operations were performed in 91 hospitals. Millions of dollars could have been saved, and the quality of care improved, if these 15,000 procedures had all been done at 30 or fewer centers. Wide variations in the per-capita consumption of various costly health services among similar populations, without any apparent differences in medical need or health outcome, suggest that there is much spending that yields little or no discernible benefit in terms of health. People might be just as healthy with half as much hospitalization."[2]

"The decisions to curtail services in order to reduce costs are and will have to continue to be political decisions, and must be made in the political arena."

And again from the article by Dr. Rogers: "For medicine (the nation's 200th birthday) also marked the end of a shorter but highly significant period in American health affairs. During the early 1960s and continuing through the 1970s, this nation markedly increased its national commitment to improving medical care for all of its citizens. It was part of a general optimism about our abilities to better the shape of our world, and Americans had high hopes, indeed, considerable confidence, that we could create in this country a society that could offer dignity, quality, and equity to all our citizens. There was a growing sense that if the nation could consciously and in a planned manner make the resources available, the professionals from the public and private sectors working together could produce a dramatic improvement in the health care available to all Americans. This optimism was encouraged by the nation's prior successes with the space program, the expanding economy, the victory over polio, and the growing level of respect for the superb technological base that had developed as part of American medicine.

"These and other successes stimulated the national mood that planned human effort plus technology had the infinite capacity to produce a better life at what then seemed to be a relatively low cost. Thus we were determined to eliminate poverty, abolish racial discrimination, eradicate substandard housing, revitalize our decaying cities, and provide equitable educational opportunities and quality health care to all."[1]

Let's examine some of

The Results of Our Spending

Continuing on with Dr. Rogers' comments, he states, "However, by the late 1960s, this sense of optimism had waned and had gradually begun to turn to a sense of disillusionment and pessimism. Doubt grew about our national capacity to achieve these social ends. We were enmeshed in a protracted war. Many had concerns about the abilities of our pluralistic American system to cope with any of the wide range of complex domestic issues that marred the quality of American life.

"Indeed for the first time since World War II, national expenditures in the health area exceeded expenditures for defense. And many were asking whether the vast amounts of monies directed toward either sector were in any way guaranteeing an improved or more secure life. Despite the enormous flow of money to health, there was the uneasy feeling at large that things were getting worse, and 'the health care crisis' was much in the discussions of the day. Medical care seemed increasingly hard to come by for all people, be they rich, poor, or middle-class. Shortages of health professionals who rendered general medical care services seemed to be growing worse. Institutions — hospitals, academic medical centers, and public health facilities — did not appear responsive to the unmet needs, and horror stories about the unavailability of care or its crippling cost to individuals were much in the public eye. The conventional wisdom as reflected by many writers of those and more recent times, was that increasing expenditures in medical care had not led to improved health, and cynicism regarding the ability of our society and our institutions to better the situation was wide-spread."[1]

Health care costs have been escalating recently at an average annual rate of 11 percent. The health care share of the Gross National Product in 1965 was 5.9 percent; it was 8.6 percent in 1977, and could rise to 10 percent within the next two or three years.

However, society has other pressing needs: helping the poor, rebuilding cities, energy conservation and environmental protection are but a few. There is no ready source of funds to pay for these increasing costs in health care and attack these other problems as well. It may take time, but the government *will* bring health care spending under control.

The question really is not whether 8 or 10 percent of the Gross National Product is too much. The question is one of priorities and benefits to be obtained for society. As society perceives the need to support other social programs, it becomes increasingly clear that change is necessary. After years of consumers' wanting unlimited care, governmental promotion of growth in production of providers and facilities, and physicians' providing services based solely on quality, it is necessary to create alternative behavior patterns for everyone.

An appropriate question now is

What Can We Do About Spending?

In 1976, the Board of Trustees of the AMA established an independent Commission on the Cost of Medical Care to provide a comprehensive overview of health-care costs and possible approaches toward solutions for the problems generated by the increasing costs. This Commission issued its full report in April, 1978. I have chosen a few comments and recommendations from this document.[7]

Some of the recommendations speak to the appropriateness of care. They urge that the medical profession and those third party payers, including government, should conduct experiments and explore ways of reducing expenditures for inappropriate care or for care in inappropriate settings. They suggest also that regionalization for high-cost, specialized services should occur. This should result in cost savings.

Several comments relate to second opinions concerning elective surgery. The statement is made that there is no

evidence to believe that second opinions are more valid than first opinions, but that if some surgery is indeed inappropriate, the practice of encouraging patients to obtain an additional opinion may have the potential for reducing unnecessary elective surgery with some result in cost savings. Another comment reflects that physicians may be demanders of health care as they make decisions on behalf of their patients. They may be recommending care that is inappropriate or medically unnecessary because of patient preference, or because of the form of payment, or because of the physician's own attitude regarding current and acceptable medical practices.

It has been stated that health care costs can be diminished by preventive care services and various types of screening. To be truly cost effective, however, early detection screening should be made available only to those populations who happen to be at risk.

Another recommendation of the Commission states that public and private organizations ought to direct more research toward solving technology-related cost problems. For example, more research might be directed toward diseases which are especially expensive to treat with current technologies. Alternatively, more research might be attempted in designing methods to utilize potentially cost-saving technologies.

Another subject discussed is the need to encourage and assist consumers and patients in becoming more active and knowledgeable in making health care utilization decisions. Education programs should be developed which inform consumers and patients about costs and benefits associated with potential and alternative courses of treatment. We should emphasize self-help programs directed at the well and the worried well, providing them with information necessary to make the initial decisions as to whether care is necessary at all from providers, and whether there are other alternatives open, such as self-care, bed rest, or the use of nonprescription drugs.

The final comments and recommendations state that, "Cost containment in health care may also be accomplished through the reduction of need for service by: the prevention and reduction of the incidence of illness through the development of more healthful lifestyles; and the early detection of incipient conditions permitting treatment through lower cost therapy."[7]

In another vein, during the last ten years in Newark, New Jersey, a reorganization of health care delivery systems and the more effective use of allied health personnel have cut infant mortality in half. Additionally, there has been a dramatic reduction in death rates from tuberculosis, cancer, heart disease, pneumonia, and accidents. All of this was achieved despite a steady exodus of doctors from Newark, which presently has about one-third of the doctor/population ratio enjoyed by the rest of the country.[5]

Generally these approaches to solving our problem of excessive or inappropriate spending attempt to find new, cheaper ways of doing old things. However, absolute reduction of spending, with limitation of some services, seems necessary as well, and now we must begin to make some hard decisions, and we recognize

The Difficulties of Change

Charles Schultze in his essay entitled *The Public Use of Private Interest,* published by the Brookings Institution in 1977, stated that, "We tend to subject political decisions to the rule, 'Do no direct harm.' We can let harms occur as the second- and third-order consequences of political action or through sheer inaction, but we cannot be seen to cause harm to anyone as the direct consequence of collective actions. . . . The rule of 'Do no direct harm' is a powerful force in shaping the nature of social intervention."[2]

Continuing from Dr. Enthoven's article mentioned earlier, and relating to this point, "The government cannot restructure the system (of health care delivery) by direct controls. Experience with other regulated industries, and with national health insurance in other countries, suggests that the government would freeze the system in its existing patterns. The 'Do no direct harm' rule has prevented the government for years from closing unneeded Public Health Service hospitals and military bases. Its attempts to close hospitals in obviously overbedded areas drown in a deluge of lawsuits and pressure from employee groups. Imagine the vested interests and the rigidity surrounding the history-based allocations among hospitals, doctors, dentists and others. It would become much more important to provider groups to defend their allocations than to serve patients."[2]

In spite of this, President Carter and many other politicians have pledged to pursue the goal of quality care for all Americans, regardless of economic status. Among the many mechanisms for achieving this, perhaps the most popular is a proposal for a national health insurance. Many leaders feel, however, that cutting costs and expanding delivery are inherently in conflict, and that containing health care costs will compromise quality, or that increased care necessarily will increase costs. Looked at overall, it seems unlikely that total costs will go down, regardless of the mechanism for paying for health services, although such costs may be redistributed.

In his Shattuck lecture, *An Agenda for Physicians and Legislators, 1976,* Dr. William Roy pointed out that we must ration scarce health care resources. But the present system of rationing — by dollars, by distribution, or by not being able to find a way into the system — are problems, not solutions. We evidently do not accept them as equitable or socially just, at least not when some form of health care is considered a prerequisite to maintaining life and liberty in the pursuit of happiness.[8]

In this article, Dr. Roy says some pretty important things: "Three medical facts of life emerge: that we cannot do everything that is scientifically possible for everyone everywhere; that if we cannot do everything for everyone everywhere, we must decide what we are going to do for whom where; and that personal health care is only *one* of the determinants of health.

"We, as a society, have long accepted this economic reality about nearly every service and product except health care."

He goes on to say, "Fuchs has put the basic economic laws simply and succinctly. 'The first is that resources are scarce relative to human wants; second, is that resources have alternative uses; and third, that people have different wants to which they attach varying degrees of importance.'

"We physicians are trained to use every available resource of possible benefit to treat our individual patients — regardless of cost. . . . Four prominent forces have caused the medical system to be characterized as a vast vacuum cleaner that will suck up all dollars made avail-

able to it: The expectations of patients; the scientific and technologic revolution; open-ended third party payment; and a physician ethic to provide all health care for each patient.

"Some of these forces are modifiable; others are not.

"Under any circumstances, few or none within our society will contend that it is mathematically or politically possible to continue indefinitely present trends in increased expenditures for health, or that it is possible even in wealthy, modern America to do everything that is medically and scientifically possible for everyone everywhere."[8]

Dr. Roy continues, "If we are going to ration personal health services, we need to know the cost benefits of such services. Likewise, if we choose to expend more resources in an attempt to intervene in the areas of human biology, environment, and lifestyle, we had better also determine the cost benefits of these efforts.

"It is increasingly necessary for physicians to measure the outcome of health services on the basis of cost benefits. In addition, physicians are expected to play a major part in deciding who will provide services and where services can be most effectively and economically and humanely provided.

"There are only two alternatives for effectively limiting total health services expenditures. One is an arbitrary government cap on payment, which to be effective requires government payment for all or nearly all services. The other is limitation of the size of the health care system by control of inputs."[8]

He concludes with, "If we cannot do everything for everyone everywhere — and we cannot — the least unacceptable alternative is for us to decide what personal health services we need and want and are willing to pay for. And then for us to make certain that the facilities and skilled people are available to provide these services on an equitable basis to all citizens of our nation."[8]

There is a total fixed dollar amount of money that can be spent in the United States. That amount is called the Gross National Product, and basically represents the energy and time of us all. Many things and services must be purchased with this total, but it represents 100 percent of what is available. When the percentage of spending goes up in one area, it must go down in another. Many feel we have passed the limit that should be spent on health.

So it seems that health care services must be limited in some fashion. This can be done in several ways: by limiting some kinds of services for all; by limiting some degree of services for all; and by limiting some services for some people or in some circumstances. Whatever solutions are found, they will not be pleasant nor agreeable to all of us. Many of the solutions may fall into the category of being the least bad thing possible. Nevertheless, decisions will have to be made and carried out.

It is unethical and unreasonable for health care providers to limit what they can do in behalf of their patients when faced with specific situations. The decisions to curtail services in order to reduce costs are and will have to continue to be political decisions, and must be made in the political arena. Making fair but unpopular decisions in a statesman-like manner for the good of the largest number of people is the ultimate reason for being for a politician. If he is unwilling to accept this difficult role, he does not deserve his office nor our support.

However, since we health providers are more knowledgeable than others regarding the appropriateness of health care and its settings, it is our responsibility to point the way and to insist that the bitter pill be swallowed.

In the final analysis, it is absolutely essential that we as a people find a way to limit some services for some people under some circumstances in order for the many to be served appropriately. Since we cannot have it all, we must decide what we *will* have, and what we are willing to pay for. These represent the hard decisions to be made that account for the difficulties of change.

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Lecture Planned on Newborn and Young Infant

Thursday, November 2, 1978, the Georgia Baptist Medical Center will present the Twelfth Annual Joseph Yampolsky Honorary Lecture. This year's topic is "Practical Management of Infections in the Newborn and Young Infant."

The lecture will take place at 7:30 p.m. in the New Tower Cafeteria, Terrace Level, Georgia Baptist Medical Center, and will feature George H. McCraken, M.D., professor, Department of Pediatrics, University of Texas Health Sciences Center, Southwestern Medical School, Dallas.

Discussant will be Andre J. Nahmias, M.D., professor of pediatrics and chief of infectious diseases in pediatrics, Emory University School of Medicine.

The program is eligible for one hour Category I credit toward the AMA's Physician's Recognition Award. Physicians, housestaff, nurses and other allied medical personnel are invited to attend. For more information, contact James S. Maughon, M.D., 300 Boulevard, NE, Atlanta, Ga. 30312; (404) 659-4211.

The author reviews the literature regarding the possible relationship between psychological factors (such as depression, stress, personality change) and the onset, as well as the clinical course, of cancer.

Psychotherapy in the Clinical Management of Cancer

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THERE IS A GROWING BODY of literature suggesting that the onset and clinical course of cancer has relationship to psychological factors.[9, 10, 25, 33] Likewise, as expected, a number of papers have been presented suggesting the application of psychological interventions to influence the course of this disease.[12,16,35,41,54,57] Simonton has prepared excellent reviews of this literature with extensive bibliographies[55, 56] justifying legitimate concern with these issues.

Currently, many investigators are compiling clinical experience that will in the future indicate more adequately the usefulness of psychotherapy as an adjunct to currently practiced medical management of cancer. Here, we wish only to indicate why it is expected that such treatment will be efficacious.

Many besides Kübler-Ross[31] have concerned themselves with improving the quality of life remaining to the terminal cancer patient.[1, 13, 23, 40] These workers have applied standard psychotherapeutic interventions to the task of relieving the psychic distress of the terminal patient. The results have been gratifying. This is not surprising, as psychotherapy in general can claim an amelioration of suffering rate of sixty to eighty percent.[6, 22] Since Weisman reports an increase in life expectancy in cancer patients with improved quality of life,[66] a simple extrapolation suggests that psychotherapy should do the same. Yalom relates the anecdote of a group of his devoted to the support of terminal breast cancer patients now containing a number of women who have lived longer than expected.[71] Simonton, using a method designed to promote remission of cancer, reports patients clinically free of the disease.[57] Meares reports regression of cancer through the use of meditation in a method very similar to Simonton's.[41] The use of meditation is now generally employed in psychotherapy of cancer where regression and remission rate is what is intended to be effected.

Depression and Cancer

The literature suggests a strong relationship between recent loss, depression, the onset of and clinical course of cancer.[25, 33, 38, 67] Animal research further suggests that this relationship may be mediated through hypothalamic-pituitary-immunologic mechanisms.[26, 27, 46, 59, 61] If we consider that many potential cancer cells are disposed of through immunological host resistance, we can understand why any influence that would depress this might increase the release of abnormal cancer cell clones.[47] This holds regardless of the etiology of the transformation of the cell in the first place.

It is expected that psychotherapy, in treating depression, may thus support an immunological host resistance that if not capable of completely destroying a cancer can at least slow it down. Literature concerning spontaneous remission[19,21,39,53] suggests the capacity of such mechanisms and perhaps that cure simply through the activation of host resistance is possible.

Hopelessness, Helplessness and Cancer

Other acute psychological factors that have been associated with the onset of cancer are the feelings of hopelessness and helplessness.[15, 51, 52] Naturally, it is understandable that this be the case, for these findings are almost universally present with and dynamically related to depression. Even if these feelings are not present before the onset of cancer, they certainly are after diagnosis. Particularly after a diagnosis of incurable cancer, these feelings with depression are prominent. The effect on further host resistance may be devastating. Achterberg et al. find

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that patients who live beyond life expectancy are just those who not only do not experience these feelings to great extent but also have strong defenses to cope with them should they arise.[2] Blumberg's hypothesis agrees with this.[8]

Here any therapy and psychotherapy in particular can aid. Therapy always presumes hope and help. Evans states, "The very fact that both patient and doctor believe that a powerful treatment is being administered is sufficient to produce a broad range of therapeutic responses in a large percentage of patients"[18] (p. 11). While he is speaking of a placebo effect, he is not taking this effect lightly. He is saying that even if, apart from our beliefs, there is no positive relationship between treatment and cure, if we believe in a treatment, then we will get a therapeutic result.

Psychotherapy has an advantage over other forms of therapy in this regard, for it is flexible enough to assure that feelings of hope and help are relatively constant. To do this, the therapist must maintain these feelings within himself, or the therapeutic system breaks down. Often enough, a breakdown of these feelings signals not a lack of reality factors, but the emergence of other feelings and the influence of motivational derivatives inimical to the very idea of cure. Obviously the dynamically oriented psychotherapist is best equipped to handle this, whether it relates to the treatment provided by himself or others.

Stress and Cancer

Perhaps the psychological factor most often incriminated as predisposing to cancer formation is stress. A review of animal studies leads La Barba to conclude that tumor induction and growth are often responsive to experiential manipulation.[32] Not only does stress effect endocrine function as is well known, but also immunological function.[58-61] That this is true in humans has been demonstrated by Fessel[20] in regard to 4S and 19S serum proteins. While these are presented merely as possible mediating mechanisms, that stress does influence incidence of and growth rate of some tumors in some animals has been demonstrated.[3,50,59] It is noted that this often depends upon the particular host-tumor system studied and the nature of the stress imposed.

While the latter complicates the situation, cross sectional studies of stress and disease and/or cancer incidence in a human population clearly indicate that increases of life stress produce higher incidence of pathology.[25,44,48,49,70] That this holds for cancer is noted by many.[36,37,45,63,64] These workers note that most of the evidence is retrospective rather than prospective and most note that further studies are in order using the latter approach.

Psychotherapy designed to influence the course of cancer with stress as a factor to be modified must be very carefully designed. While one need be aware of supporting techniques as constantly available for decreasing stress, the psychotherapist must use his knowledge of psychodynamics to discover unconscious sources of stress to defuse these even if temporary increases of anxiety result. Often stress as a result of environmental occurrences may be reduced by discovering how the patient views these such that anxiety results. Anxiety then decreases as the patient is helped to understand other alternative points of view.

The introduction of meditation as part of the process of cancer psychotherapy[41,57] in large measure may be effective because of the induced "relaxation response"[5] and the generalization of this to decrease overall stress.

The diagnosis of cancer generally causes considerable increases in anxiety-stress. The psychotherapist can do much to aid in decreasing this. The psychiatrist with his medical training has a distinct advantage here as he is in a position to understand medically what is happening and may easily reassure the patient. At the same time, he may judiciously use medication to accomplish the same purpose.

Personality and Cancer

Personality is a difficult subject at best. Needless to say, the literature attests to this in its multiplicity of theories. Correlating this type of data with cancer data, itself often subject to error, leaves much to the imagination. Despite these major obstacles, some personality factors correlated with the presence of cancer seem to emerge. We have mentioned the appearance of depression and stress prior to the clinical onset (discovery) of cancer. Articles suggesting particular patterns of handling anger or stress[8,17,24,28,29] fit current dynamic conceptions of depression as often involving anger directed toward the self and defensiveness as guarding against anxiety. The observation that these personality features correlate with the presence of cancer is interesting, for, from our understanding of these personality types, we would conclude that they foster chronic smoldering depression and anxiety (stress). We suppose these affects to produce, or at least be present with, corresponding physiologic states. If these states also include decreased host resistance, then these personalities would indeed be conducive to cancer.

Some authors have noted that women with cancer of the breast or genital organs have marked inhibition of sexual drives.[4,64,65,68] Schmale[52] has achieved predictive accuracy with this information.

A number of authors[2,9,29,63,67] have studied the personality of patients with rapidly progressing disease as opposed to the personality of patients with

slowly progressive disease. Here again we find statistically sound work and significant differences in the groups. Much of the data agrees with data we have discussed already.

The Psychotherapy of Cancer

A psychotherapy designed to treat cancer assumes interactions between mind and body through a broad interface which we will term the psychophysiologic mileau. This mileau contains psychodynamic and physiologic features of the individual in equilibrium states fluctuating interdependently with all other features (components) of the mind-body system. These fluctuations are etiologically the result of numerous influences originating within and outside of the system. In the cancer patient, not only the presence of decreased host-resistance but also the tumor itself are presumed to be features of the functioning system that represents the patient. The psychotherapist, using himself and his relationship with the patient, hopes to strategically influence this system and its mileau. In changing both preexisting and currently existing constellated psychodynamic features, it is presumed that corresponding physiological variables will change also. The therapy plans that this change will be away from whatever existed previously which is correlated with the decreased host resistance and the presence of cancer.

The cornerstone of cancer psychotherapy is the creation of an attitude of hope and desire to live. Assuming that both of these are low-to-absent in the terminal patient, renewal of the first simply requires the patient's and physician's belief that something is being done that promises to be efficacious. We could do such with a placebo except that we do not believe in the placebo.

The patient who has given up on life generally has not given up simply because he or she has cancer. The findings of so frequent a connection between recent loss and onset of the disease suggests hopelessness and giving up as related to the loss.[36] The patient in giving up, gives up fighting not only for gratification of some basic needs but may give up fighting for survival. Not only may this be reflected on a physiological-cellular level but often enough delays seeking of medical attention which might offer survival. This is an interesting example of the invasion of the system by a motivation override influencing diverse areas of behavior.

Standard therapy designed to influence personality-characterological changes struggles with the issues that promote a position of despair and giving up. Often the cancer itself is seen as symbolic of figures in the struggle and we may observe how their destructive incorporation into the mind-body system represents a solution to the despair.

But standard psychotherapy takes too long. Patients could be long dead before character modification occurs sufficient to significantly alter the long inbred constellations of mind-body components (features) associated with the onset and progression of the disease.

Meditation and visualization bridge the gap. This technique, independently pioneered by Meares[41] and Simonton[57] combines the benefits of meditation[5, 14] with many other factors including a possible focusing effect of "healing energy."[34, 42, 43] The evidence for and speculation concerning the latter are well beyond the scope of this paper, yet the effect is also explainable in the physiological terms we have been discussing. It may simply boil down to belief. Belief in the technique produces hope and decreases anxiety. We do know that meditation itself changes the physiologic mileau.[5] It may simply be a case of autogenic visceral control. In addition, meditation shares many similarities with hypnosis and practitioners of this technique are currently noting structural physical changes as a result of its use.[62, 69] Willard's technique is very similar to what we use and he anticipates its use in medical conditions including cancer[69] (p. 199). The meditation currently used in cancer psychotherapy induces an altered state of consciousness with its attendant "relaxation response." Within this framework, the patient is instructed through the use of cassette tapes to visualize the body's defenses destroying the cancer. We are not concerned with anatomical representation, but use the symbolic images the patient provides. Modifications of instructions allow control of side effects, visualizing the medical attack, avenues for further understanding of the psychodynamic features of the individual in relation to the cancer and through visualization of desired goals in life, the installation of hope for the future. The details of this process are fascinating indeed and warrant a future article.

The psychotherapy of cancer then utilizes a broad front of attack attempting to interrupt previous constellated patterns of attitude-mood-physiology, inducing new patterns conducive to relaxed, assertive, more satisfied existence, increased will-to-live and increased host resistance. Often we use only the possibility of success to increase hope and staying-power, buying the time necessary to make progress in the painstaking task of character modification.

The therapy is not done without other medical management. The patient is encouraged to pursue all recognized as efficacious. Often the therapy enlists the patient's aid through the meditation to deal with side effects which might normally halt or slow down an aggressive medical attack. This alone should increase life expectancy.

Finally, by actively facing and dealing with the possible approach of death, not only may the patient release new energies for change and growth,[30] but

surely should make his last days in life more rewarding and pleasurable.

Discussion

Traditionally, modern medicine views the mind and body as separate. An excellent review by Le Shan[33] demonstrates that at least in relation to cancer this was not always the case. A psychotherapy of cancer threatens a dualistic view. Not only does it presume broad connections between mind and body, but it often overlooks any separation whatsoever. The latter may simply be expedient, but as often as not represents a world view considerably enriched by the inclusion of Eastern thought.

We currently treat the mind through the soma quite successfully, should we not anticipate, as in any equilibrium state, that movement in the other direction is not only possible but is a reality? This is of course no revolutionary point of view. Psychosomatic medicine has addressed itself to the task for years. What is new is the possibility that by approaching a particular somatic problem through a combination of experiential and somatic therapies, we may abort an otherwise terminal condition by virtue of the addition of experiential therapy.

Those of us who are serious about psychotherapy note that even in psychological problems alone it can work for better or for worse. This requires of a cancer psychotherapy that close contact be maintained between psychotherapist and others engaged in the treatment. We want to be aware of progression of the cancer constantly. We want to know what therapies are being used and what side effects we can help deal with. It is within the realm of possibility that anemias, leukopenias and thrombocytopenias respond to meditation.

The possibilities offered by this belief system and techniques are both exciting and frightening. It is clear, however, that for the majority of medical practitioners, more statistical evidence of efficacy is needed. Simonton has a fine series of cases but has yet to publish the data. Actual randomized samples from clinical material need comparison with and without psychotherapy. As mentioned previously, prospective studies of large populations testing presence of personality features against later appearance of cancer are in order. Blumberg[8] has characterized a "cancer profile" with the MMPI. Pre- and post-psychotherapy testing might note changes in this profile and correlate these with the progression of the cancer.

Summary

Much literature attests to the link of the mind and body in the course of cancer. This suggests the possibility that experiential methods of treatment be added to the growing medical armamentarium dealing with the disease. A method of psychotherapy has been developed to create changes in the psychophysiologic mileau of an individual across a broad front suggested from numerous sources. It is expected that this increase host resistance, longer life span and hopefully some "spontaneous regressions." However, while face validity of the treatment appears sound, more statistical evidence is called for.

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Suprarenal Mass: Renal or Adrenal?

RICHARD GORDON, M.D., CHRIS MURPHY, M.D., and
AYTEN SOMEREN, M.D., *Atlanta**

Dr. Richard Gordon: Our first case is that of a 57-year-old male who presented with a two month history of crampy, subcostal and lower back pain. He also complained of lower extremity weakness and claudication. He stated that he had two episodes of hematuria and one episode of melena during the week prior to admission. Physical examination was unremarkable. The patient's initial work-up included a negative upper G.I., barium enema and oral cholecystogram. The patient also had a negative IVP. Because of the patient's claudication and lower extremity weakness, peripheral vascular disease was suspected and the patient had the appropriate vascular studies to evaluate this.

Dr. Murphy, will you discuss the radiographic findings?

Dr. Chris Murphy: As is the usual procedure in evaluating peripheral vascular disease, an abdominal aortogram was obtained prior to the filming of the run-off. On the early aortogram, there is a suspicious tangle of irregular appearing vessels overlying the superior pole of the right kidney. On later films, there is a nodular blushing mass over the superior portion of the right renal nephrogram. However, projecting through this mass there appears to be an intact renal cortical outline. The remainder of the aortogram and the run-off are unremarkable. In light of the renal finding, may I review the negative IVP.

Dr. Gordon: Here are selected films from the IVP.

Dr. Murphy: The films from the IVP show that the outer cortical margin of the right kidney can be traced around the entire kidney. The upper pole margin is slightly less distinct, however. The collecting system appears normal.

* Emory University School of Medicine, 80 Butler St., SE, Atlanta, Ga. 30303. Drs. Gordon and Murphy are from the Department of Radiology and Dr. Someren is from the Department of Pathology.

Dr. Gordon: What would be your next step in evaluating this lesion?

Dr. Murphy: I would like to see films of a selective injection of the right renal artery.

Dr. Gordon: Here are selected films from the right renal arteriogram that was subsequently performed (Fig. 1).

Dr. Murphy: On the early and mid arterial phases, there is again noted to be a tangle of irregular, tumor-like vessels overlying and projecting above the superior pole. There are areas of dense staining within this mass, and on the nephrogram phase, again this region has a nodular margin. The renal cortical margin is disrupted in the area of the mass.

My impression at this time is that the lesion represents a tumor involving the superior pole of the right kidney with its vascular supply primarily from the renal artery. This tumor is most likely a renal cell carcinoma. However, because of the location, an adrenal tumor invading the kidney from above cannot be completely excluded. A renal hamartoma can present with this hypervascular appearance, but these tumors are usually multiple and bilateral, and are often found in association with tuberous sclerosis.

Dr. Gordon: This patient had no other findings of tuberous sclerosis. Because of the questionable origin of this mass (renal vs. adrenal), a CAT scan was performed (Fig. 2).

Dr. Murphy: Serial CAT scans at one cm. intervals through the abdomen performed following the administration of oral and IV contrast revealed the mass to be adjacent and inseparable from the superior lateral and posterior aspect of the right kidney. Normally the adrenal glands are seen to the superior, medial, and anterior aspects of the kidneys.

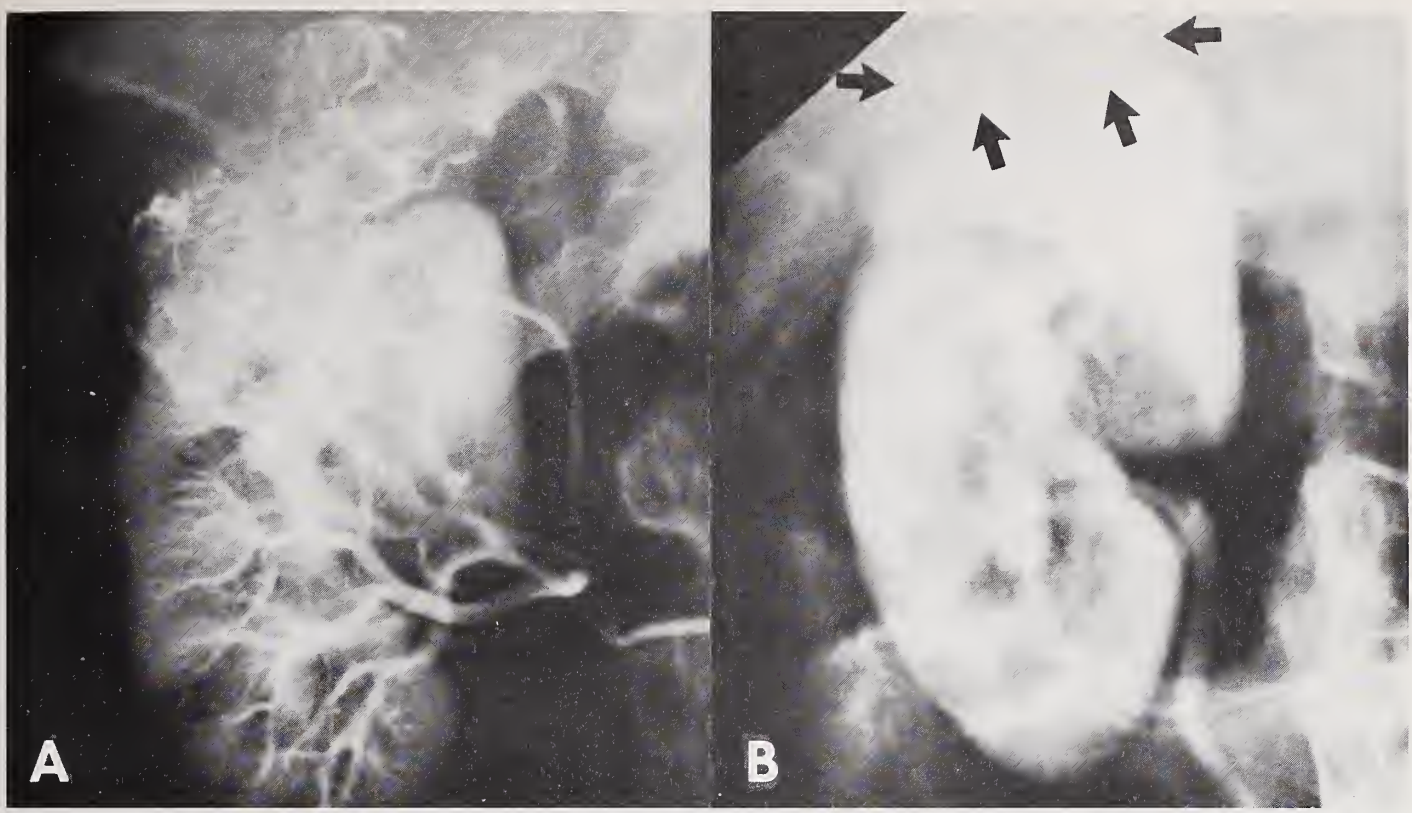


Fig. 1 — A. Arterial phase of the selective right renal arteriogram demonstrating a tangle of irregular tumor vessels overlying the superior pole of the right kidney. B. Blush over the right kidney on nephrogram phase with areas of staining within the tumor.

Thus, the mass is clearly shown to be renal and not adrenal in origin.

Dr. Gordon: The patient was further investigated with a negative liver-spleen scan and a negative brain scan and then underwent nephrectomy.

Dr. Someren, will you discuss the pathological findings?

Dr. Ayten Someren: The specimen was received in fresh state and consisted of right kidney with attached perinephric adipose tissue and right adrenal. They weighed approximately 380 grams. On sectioning, in the region of the upper pole, at a peripheral location, a fairly well circumscribed lesion measuring 6 × 4.5 × 4 cm. is noted. Cut surfaces of the lesion showed an appearance varying from whitish tan areas to hemorrhagic focci. Attached adrenal gland showed no gross abnormalities and appeared grossly free of tumor. Main renal vein showed no gross evidence of tumor invasion. Renal artery, ureter and remaining portions of the renal parenchyma appeared grossly unremarkable.

Microscopically, the lesion showed the typical picture of renal adenocarcinoma. Histologically, the tumor was composed predominantly of clear cells with fairly uniform nuclei and clear cytoplasm, forming alveoli nests and groups, separated by thin strands of richly vascularized fibrous stroma. In some areas, the cells assume spindle shape and showed more pleomorphism. Portions of the tumor showed hemorrhage and fibrosis. Perirenal adipose tissue was invaded by the tumor at the upper pole, but the adrenal gland is free of tumor and all sections examined. Section of the main renal vein showed no evidence of tumor invasion.

Dr. Gordon: Could you give a short discussion of renal adenocarcinomas?

Dr. Someren: Although many names such as Grawitz's tumor, hypernephroma, renal cell carcinoma, and clear cell carcinoma have been used for this interesting tumor, it is now known that it arises from the proximal convoluted tumular epithelial

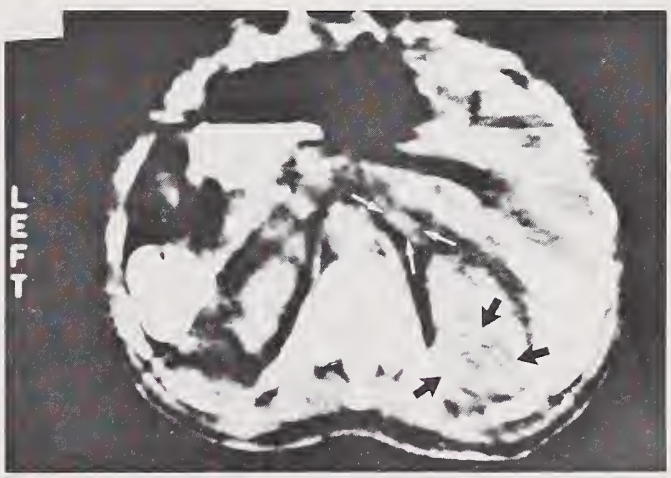


Fig. 2 — Computerized axial tomography section taken at the level of the upper right kidney demonstrating a mass involving the posterior aspect of the right kidney (black arrows). The adrenal gland can be seen to the anterior and medial aspect of the right kidney (white arrows).

cells. The age range for patients with renal adenocarcinoma extends from 6 months to old age with the peak incidence being at the 6th decade. They are, however, rare in children, fewer than 100 cases being reported in the literature. The tumor affects more males than females.

Although hematuria, pain and flank mass is the triad regarded as the classic mode of presentation, the earliest signs and symptoms of renal adenocarcinoma are usually non-urologic. These nonspecific signs include pyrexia, weight loss, fatigue, G.I. complaints, neuromuscular abnormalities, etc. Some patients present with physical manifestations of localized metastases such as hemoptysis, skin nodules, etc. Histologically, the tumors may be composed of clear or granular cells, arranged in tubular, papillary, solid and cystic patterns. Rarely, the tumor is focally or completely spindle cell, resembling fibrosarcoma or myosarcoma. The tumors usually show little cellular and nuclear pleomorphism. Large amounts of intracellular cholesterol, lipid and glycogen give these cells the typical clear cytoplasm when examined under the light microscope. The tumors are richly vascular.

Metastases are present in one-third of the patients with renal adenocarcinoma at the time of diagnosis and at autopsy they are present in 90% to 95% of patients. Common sites of metastases are brain, lung and bones.

Spread of malignant disease occurs by three different routes: hematogenous, nephrohematogenous, and lymphogenous. Spread by hematogenous route is more important in renal adenocarcinoma than for most other cancers. Tumor cells invading the renal vein may spread; 1) retrograde to pelvic structures via the left spermatic or ovarian vein, 2) along the axial skeleton by way of the paravertebral vein, 3) up the vena cava to the right heart to the lungs or 4) after passing through the pulmonary circulation to multiple sites by arterial circulation. Prognosis in general is poor. Overall survival rate is 18% to 27%, ten years after nephrectomy. In spite of slow growth, unfavorable outcome is most probably due to silent growth frequently presenting with metastases as the first symptoms or the patient's delay to seek medical help.

Dr. Gordon: This patient went on to develop progressive lower extremity weakness during his hospital stay and films of the thoracic spine demonstrated a metastatic lesion with destruction and collapse of the T-8 vertebral body.

Discussion

In some cases of suprarenal masses, the origin of the tumor whether it be renal or adrenal can be difficult to determine even after angiography. The blood supply of the tumor, whether from the adrenal or renal artery, may be helpful in making this diagnosis. In this case, computerized axial tomography (CAT) scan was extremely useful in identifying the origin of the tumor and made possible a preoperative diagnosis.

The apparently negative IVP in this patient is understandably possible in light of the arteriograms and CAT scans. The CAT scan revealed that the tumor is localized posteriorly and on the angiogram the normal anterior cortical margins of the right upper pole projects through the area of the lesion. Therefore, the ability to see an upper pole margin on the IVP was misleading. Also of note was the benefit of the preliminary aortogram in revealing unsuspected disease prior to the run-off.

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Breast Reconstruction Following Mastectomy

JOHN BOSTWICK III, M.D., L. O. VASCONEZ, M.D., and M. J. JURKIEWICZ, M.D., *Atlanta

NINETY THOUSAND WOMEN will develop breast cancer in the United States this year. Most of them will have a radical mastectomy for local treatment of their tumor. Due to increased patient and physician awareness, many of these tumors are found while quite small. While survival is, of course, the primary goal of therapy, many women find it quite difficult to face simultaneously the prospect of possible death from cancer and the permanent loss of their primary symbol of femininity.

Many surgeons are ameliorating the post mastectomy defect by preservation of the pectoralis major muscle (modified radical mastectomy), transverse or oblique skin incisions, careful skin closure and somewhat thicker skin flaps consistent with good tumor excision rather than routine skin grafts.

After radical mastectomy, a number of these women remain depressed and mourn the loss of their breast. Further interest has also been stimulated by a number of articles concerning breast reconstruction in the lay press. There are an increasing number of patients requesting rehabilitation following mastectomy.

Who Should Be Reconstructed?

Women who indicate either preoperatively or postoperatively an interest in reconstruction should have a consultation with a reconstructive surgeon. Advanced local disease in the breast or axilla certainly precludes a reconstruction because of the high risk of local recurrence.[1] Close communication between the general surgeon and the reconstructive surgeon is essential. The reconstructive surgeon should perform the reconstruction with the full knowledge and advice of the general surgeon. Ideal candidates for reconstructive surgery have a small tumor without involved axillary nodes. The general surgeon should feel he has extirpated the tumor locally prior to any reconstruction.

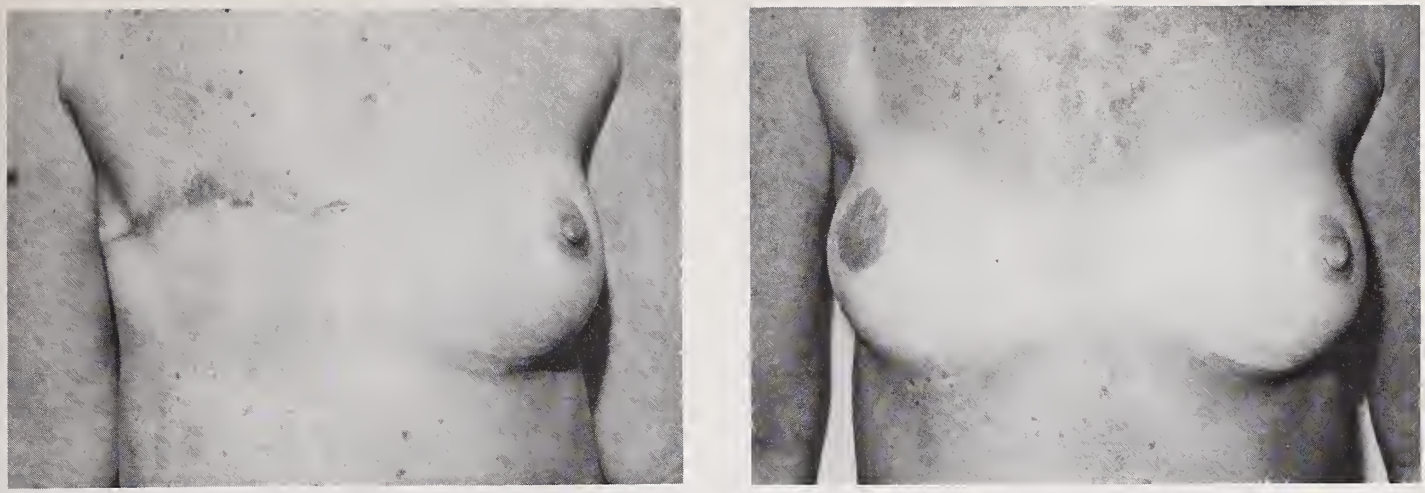
Factors such as nipple-areola storage,[2] pectoralis muscle preservation, position of incision, thickness of flaps, and type of closure are technical aspects which the general surgeon should consider. Preoperative consultation with the reconstructive surgeon can be of value. These factors can certainly affect the success and final result of the breast reconstruction.

Patients who are free of local disease two to three years following the mastectomy have an extremely low incidence of local recurrence and are also excellent candidates for reconstruction. Patients with larger tumors or spread beyond the lowest axillary nodes have a higher incidence of local or systemic recurrence. We have not reconstructed these patients. The patient must be aware of these risk factors and participate in the decision for or against reconstruction.

Patient Material

Thirty-five patients have been reconstructed following radical mastectomy at Emory University Affiliated hospitals (see the table). The follow-up is from three years to three months. We have not yet had a patient with local recurrence following breast reconstruction. Of course, statistically, in a longer

* The Division of Plastic, Reconstructive and Maxillofacial Surgery, Joseph B. Whitehead Department of Surgery, Emory University, 25 Prescott St., Atlanta, Ga. 30308.



Left — 28-year-old patient one year following a mastectomy; Right — One year following breast reconstruction with a silicone prosthesis, areola reconstruction with labial graft and nipple reconstruction with auricular cartilage.

follow-up, a few women will develop local or systemic recurrences.

Specifics of Reconstruction

Until recently, very few women had post-mastectomy breast reconstruction. This was primarily because the reconstructive surgeon could only offer a multi-staged, time-consuming series of operations. These left rather large donor defects and were usually esthetically disappointing. The broad experience gained over the last few years from the use of silicone breast prostheses, reduction mammaplasty, mastopexy, and subcutaneous mastectomy with immediate reconstruction has given reconstructive surgeons the basic techniques for post-mastectomy breast reconstruction. Recent developments of longer arterialized skin flaps in the upper abdomen[3] and muscle and musculocutaneous flaps of the latissimus dorsi[4] enable the surgeon to readily provide sufficient tissues for reconstruction in one or two operations.

The mastectomy defect often includes tight, thin skin, infraclavicular flatness and prominent ribs from removal of the pectoralis major muscle, absence of the breast mound, and absence of the nipple-areola. The opposite breast is often hyperplastic, hypoplastic or has mammary ptosis. The opposite breast also is at significant increased risk for developing a second primary breast carcinoma.[5] Total rehabilitation usually includes reconstruction of the missing tissues on the mastectomy side and also a subcutaneous mastectomy and appropriate reconstruction and reshaping of the opposite breast. This attains symmetry while decreasing the risk of a second primary breast carcinoma. While many women can tolerate a single mastectomy, bilateral mastectomy can be psychologically devastating.

Usually enough skin remains after the mastectomy to accept a subcutaneous silicone breast prosthesis. When additional skin is necessary to resurface the anterior chest prior to breast reconstruction (such as cases with a previous skin graft or radiation damage), additional skin may be obtained by a transverse skin flap transposed from the ipsilateral upper abdomen. The donor defect is closed with a single line which may be covered by the brassiere.[3] The breast mound is reconstructed with a silicone prosthesis. Special modification (custom fabrication) can give additional fullness in the axillary area of the infraclavicular area.

The modified radical mastectomy preserves the pectoralis major muscle and obviates the infraclavicular hollowness. In patients with a radical mastectomy, this infraclavicular defect significantly restricts the clothing choice. The infraclavicular area may be filled by the anterior transposition of the latissimus dorsi muscle. The muscle is sutured to the clavicle and sternum to simulate the missing pectoralis major muscle. The incisions for obtaining the latissimus dorsi muscle are two short ones — one in the axilla and one at the transverse bra strap line on the back. If additional skin and muscle are needed anteriorly, a compound musculocutaneous island flap of latissimus dorsi muscle and a segment of its overlying skin may be transposed. The donor incision defect is closed as an oblique linear scar on the back.[4]

Reconstruction of the nipple-areola is best accomplished with similar tissues. If the primary breast carcinoma is distant from the nipple and biopsy beneath the areola is negative for tumor, the nipple-areola complex may be stored as a full-thickness graft in the groin for use in future reconstruction.[2] The opposite nipple-areola may be shared in a

BREAST RECONSTRUCTION FOLLOWING MASTECTOMY

Subcutaneous prosthesis insertion	20
Omentum	2
Transverse abdominal flap	2
Latissimus myocutaneous flap	8
Latissimus muscle flap	5
	37

Follow-up is from three months to three years.

number of ways for reconstruction. If it is small, a split skin graft may be taken and placed on the reconstructed breast.[6] If the nipple-areola is larger, and concomitant surgery is performed on the opposite breast, such as a subcutaneous mastectomy or reduction mammaplasty, the opposite nipple-areola may be halved and two slightly smaller nipples reconstructed.[7] The retroauricular region[8] (Fig. 1) and upper inner thigh region may also be used for nipple-areola reconstruction.

Complications associated with breast reconstruction are similar to those seen in prosthetic insertion of silicone mammary prostheses. The tight skin can result in a firm breast. In addition, the possibility of skin necrosis exists — if a hematoma or infection occurs. Local recurrence of the breast tumor is always possible. This can be minimized by extremely careful pre-operative selection of patients. There is, however, no evidence that breast reconstruction increases the possibility of local recurrence.

Summary

Many women are requesting reconstruction after radical mastectomy. Cooperation between the general surgeon and the reconstructive surgeon is essential to rehabilitate these women.

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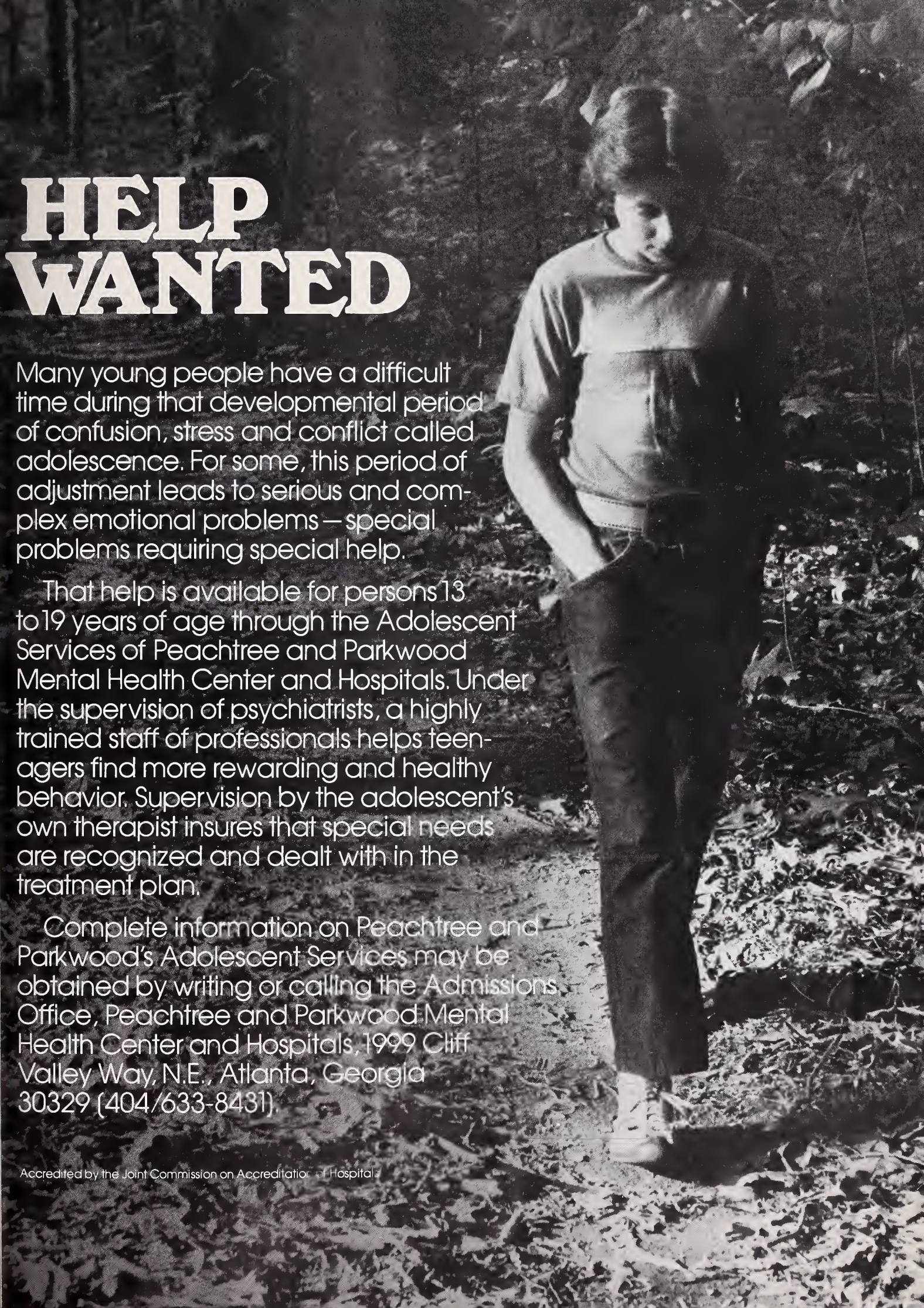
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Scientific Assembly—A New Approach

FROM NOVEMBER 11 THROUGH November 14, the Medical Association of Georgia will be part of a new endeavor in continuing medical education. These are the dates when the Scientific Assembly of the Medical Association of Georgia joins with the 72nd Annual Scientific Assembly of the Southern Medical Association to present the most comprehensive medical meeting ever for our state.

This conjoined venture is the brainchild of MAG's Dr. Ed Evans who is also Georgia's councillor to the SMA and vice-chairman of its executive committee. With the blessing of the approving bodies of both organizations and the guiding hand of the SMA's President, Dr. Andrew Giesen Jr., the Georgia specialty society program chairmen met with the section secretaries of the SMA in a planning session, and the program was underway.

It was anticipated that such an ambitious undertaking would be blessed with a few problems, but under the expert guidance of Dr. C. Rex Teeslink, chairman of SMA's Committee on Scientific Work and a member of MAG's committee on Scientific Assembly, differences were resolved, problems solved, and a program planned that will make both organizations proud of their combined efforts.

The traditional luncheon and Abner Calhoun Memorial Lecture Meeting will be held on Saturday, November 11.

There has been splendid cooperation between the auxiliaries of both the MAG and SMA. Mrs. Bruce Martin, President of the SMA's auxiliary, is working with her local co-chairmen, Mrs. David Thibodeaux and Mrs. James Manning, on a program that will keep the spouses enchanted and busy.

While it would perhaps be an overstatement to say that the eyes of the nation are upon us, there has been considerable interest expressed by other state societies and organizations concerned with continuing medical education and planning. With the escalating costs of preparing programs for medical education and the increasing interest in medical cost accountability, the "meeting watchers" will be observing the results of our combined effort with particular interest.

While the interest is on the programs of the twenty-three specialty sections, the meetings of the conjoined societies, the postgraduate courses, and the SMA Learning Center, the meeting will not be without its fun side. Dr. Dick Margeson of the MAG has planned the annual golf tournament. There will be a tennis tournament, and Dr. Margeson promises to try to put a jogging contest together. The SMA President's Reception and Luncheon as well as the President's Night, featuring a hospitality hour and a dinner dance, will highlight the social side.

I urge each of you to attend. Register now!

E. Napier Burson Jr., M.D.
Chairman, 1978 MAG Scientific Assembly

A Letter to the Officers of MAG . . .

Gentlemen:

At our June meeting, we discussed the reaction to the June issue of the *Journal of the Medical Association of Georgia* in which the cover illustration of the special issue on breast cancer used a photograph of the Grand Teton Mountains.

Most of us found the illustration, in that context, offensive, and wish to call this to your attention. It was deemed inappropriate and sophomoric to joke about cancer or serious illness. Perhaps these viewers did not perceive the humor in the same way that the editorial staff of the *Journal* or Dr. Garrett did. Incidentally, we observe that there are no women listed on the editorial staff nor on the Publications Committee of MAG.

We are calling this to your attention since the *Journal* is the MAG to many physicians and conveys the regional and national image. We are certain that the MAG does not want to offend any of its members or constituency or other readers.

Sincerely
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president's letter



1978 Scientific Assembly

PLEASE ACCEPT this cordial invitation to attend the 1978 Scientific Assembly, co-sponsored by the Medical Association of Georgia and the Southern Medical Association.

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This will be the largest continuing medical education effort to date for the Medical Association of Georgia, and will be the most comprehensive medical meeting of its kind, ever.

All specialties will be represented in the 65 scientific sessions, 17 postgraduate courses, and 260 available hours of AMA Category I CME credit.

Combine these activities with the annual MAG luncheon and Calhoun Lecture, alumni gatherings, specialty society business meetings, a variety of planned spouse activities, social events, plus great entertainment, and it adds up to a "super session," November 11-14, 1978, at Atlanta's World Congress Center.

We are expecting a large turnout of SMA members. Let's break all records for MAG attendance. See you in Atlanta!

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
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I've told this before . . .

(Editor's note: What is the best medicine for unhappiness? One good answer is demonstrated in this story by Dr. Leigh. Others wishing to contribute to this page are invited to send their stories to the Journal, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

What's in a Name

MISS RHODES, please make up a new folder, and type up this dictation on our new patient.

January 6. Miss Julie Williams, female, single, age 26.

Clinical History: Miss Williams' chief complaints are those of nervousness, poor appetite, and easy fatiguability. She states that these symptoms have been present continuously for about four years, varying to some extent in degree, and always worse in the spring.

She does not date their onset to any specific instance, but believes that they started soon after her graduation from college. During college, her health was perfect; she liked her work, made creditable grades, and entered into many college activities.

Since college she has worked as a secretary with an established firm here in town; she states that she does well at her work, but does not enjoy it.

Her family history is essentially negative. Her mother and father are living and well. She has three married sisters and one married brother, all living and well.

Examination shows the patient to be an attractive blonde, appearing to be approximately her stated age. She is slender, but not undernourished. Her temperature, pulse, respiration, and blood pressure are normal. The head and neck, chest, abdomen, and extremities all are normal. Neurological examination reveals no significant positive findings.

The routine lab work done in the office here is negative.

My impression is that her complaints are largely psychoneurotic in nature, but I am going to refer her to a radiologist for a gastrointestinal work-up, and for skull films.

I have prescribed a mild sedative in the meantime.

She is to return on the 15th.

Signed, Robert Ames

January 16. Miss Williams was again seen today. She has now had her X-ray studies and they were all negative. The sedative apparently did not help her; as a matter of fact, she states that her nervousness and poor appetite have been worse during the past ten days.

I had an hour's talk with her today, covering many subjects, in an effort to find an underlying basis for her symptomatology. I cannot say that I was very successful. Her nervousness was quite apparent during the interview. In addition to that, she has a great deal of apprehension and fear over something or other — I have not yet found out what. I doubt that these are real and I feel confident that they have a great deal to do with her complaints.

February 4. No apparent progress.

February 12. No progress. The patient is essentially unchanged.

April 25. During the past two months, I have had six interviews with Miss Williams, and I doubt that I have benefited her at all. I have suggested on several occasions that I send her to a psychiatrist, but she will have none of it. She seems to enjoy our interviews, and states that they are doing her some good. I am sure there is a basis for her symptoms, but so far, it has eluded me.

May 4. No progress.

May 20. The patient's symptomatology has miraculously changed for the better almost over night. She is a new person entirely now. She states that she is completely relieved of her nervousness, that she no longer suffers from fatigue, and that her appetite has never been better. I cannot detect any of the apprehensions which she so thoroughly manifested only a few short days ago. It is gratifying to see such a complete change in her physical condition and in her mental attitude. I am discharging her now with the final diagnosis of "Psychoneurosis, cause undetermined."

Miss Rhodes, when you finish typing this final note, you might as well file Miss Williams under the new name which she will have as of June 7 — Mrs. Robert Ames.

Ted F. Leigh, M.D.
Emory University Clinic
Atlanta, Ga. 30322

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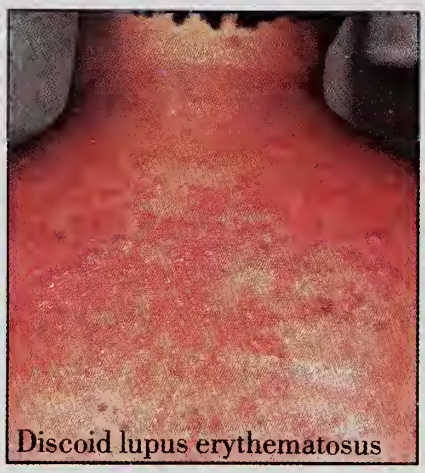
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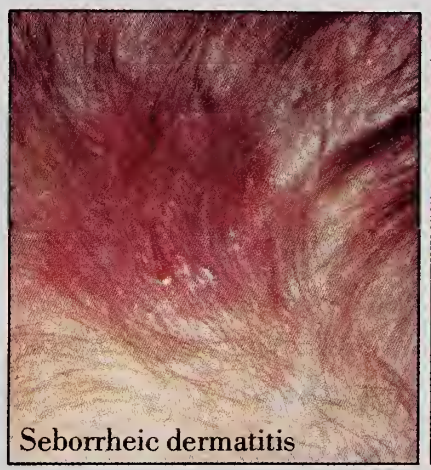
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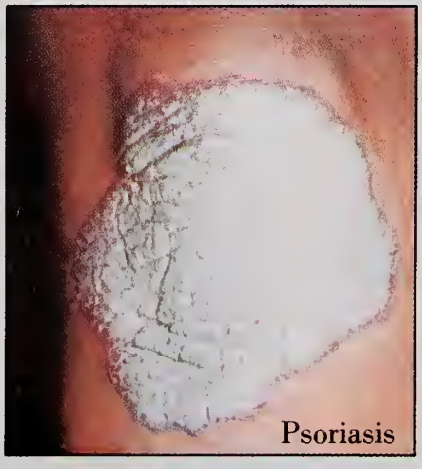

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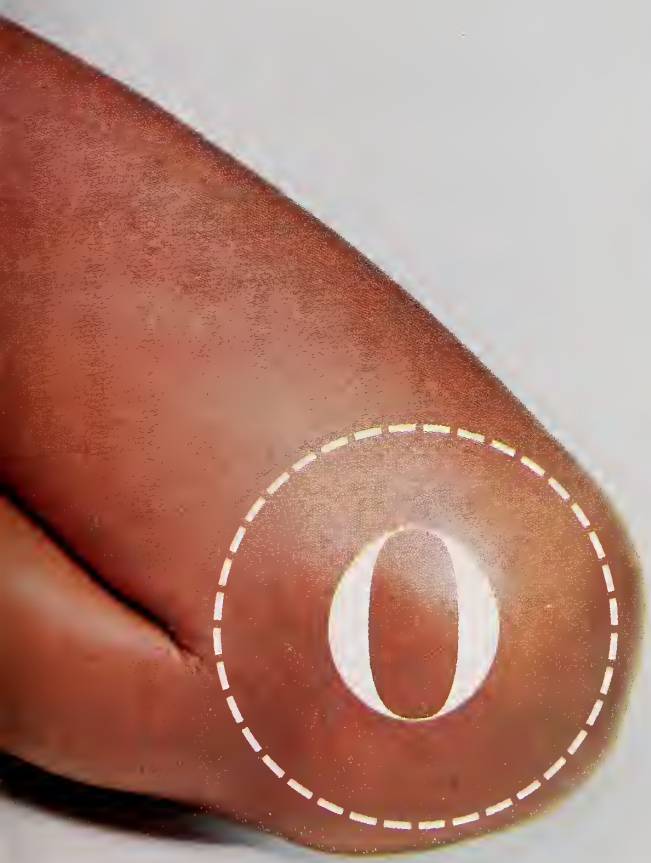

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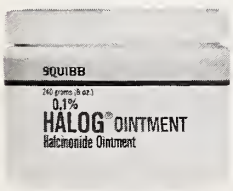
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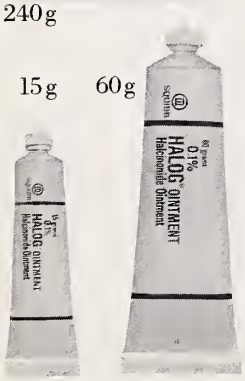
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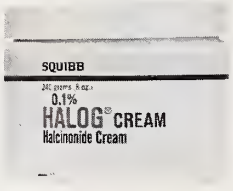


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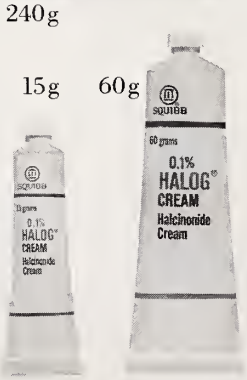


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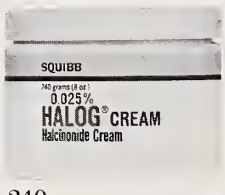


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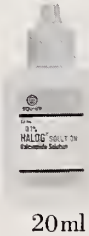


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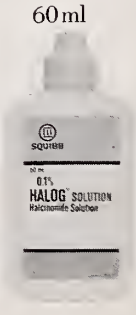


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Reconstruction as a Part of Rehabilitation

LaMAR S. McGINNIS, M.D., *Decatur**

THE JUNE ISSUE of the *JMAG,* was devoted to a discussion of the general topic of breast cancer and included excellent articles on mammography, on indications of risks in breast cancer, on detection including high-risk factors, on new directions of therapy, a statistical review of breast cancer in Georgia, and an editorial discussing diagnosis and management. I feel that the subject of post-mastectomy reconstruction was unintentionally neglected; and in this issue of the *JMAG,* Dr. John Bostwick offers an outstanding discussion of this contemporary topic. I would commend it to you for your thoughtful consideration.

Last year I had a most interesting consultation in my office with a woman who was 4½ years post-mastectomy. She subsequently wrote a letter to me which I found most enlightening and stimulating, and I will now quote from her letter:

"Thank you for listening and encouraging me to explore the possibility of breast reconstruction. Indeed, before now, I have had no encouragement that there could be any improvement. I have made an appointment with a plastic surgeon. I realize this surgery may not be possible for me — but I have to find out.

"I was much encouraged by the articles in the newspaper about Dr. Cronin and his work. He seems to really understand the problems so many of us face.

"You asked me to write of how I feel about my surgery — it is difficult to put into words. I have felt ashamed that I could not simply feel grateful just to be alive — my family was. Of course, life is precious, but life and living have different values for each of us.

"For me, mastectomy meant more than removing a dangerous appendage that filled out my clothes. It meant taking away a very real part of me as a total being — a complete person. How I would look in clothes or appear to others (except my husband) was not and is not the problem — but how I feel about myself — the need to feel like a woman — to accept myself — this has been so difficult.

"Only within the past year have I been able to talk about this with my husband — it does help that he now realizes how I feel. He had always said it didn't make any

* Vice Chairman of the Board, Georgia Division, American Cancer Society. Dr. McGinnis' address is 365 Winn Way, Suite 201, Decatur, Ga. 30030. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

difference — but it does. He has been a rock through it all — even when he couldn't really understand. He is hopeful that plastic surgery will help.

"I have not been sitting around feeling sorry for myself, that is not my style. I always had a great zest for life. I have kept busy doing most of the things I did before my surgery, but it isn't the same, nothing is quite as good. I have a constant reminder that I am not whole — every breath I draw."

I have encountered the concern about "not feeling whole" expressed by post-mastectomy patients, in the literature, and in my own experience, so that I know this is a frequent major concern. Certainly the great majority of post-mastectomy patients do not desire reconstruction; however, I am becoming more and more convinced that probably a most significant factor in motivating women to come in for early detection would be the knowledge that some type of reconstruction is available.

Dr. James Bennett, professor of plastic surgery at the University of Indiana School of Medicine, recently stated, "Regardless of the nature and extent of the ablative operation, the surgeon treating breast cancer should consider, from the outset, the possibility of later reconstruction. Incision placement, skin flap thickness, and careful wound closure can facilitate surgical rehabilitation without compromising surgical philosophy."

The American Cancer Society has issued a policy statement regarding post-mastectomy reconstruction (printed below). Our initial aim continues to be the cure of the cancer patient and the return of that patient to a good functional life. Early detection of breast cancer, and the rehabilitation of the post-mastectomy patient, are inexorably bound with the knowledge that reconstruction techniques are available and can be carried out successfully.

American Cancer Society, Georgia Division, Inc., Statement on Reconstructive Surgery After Mastectomy

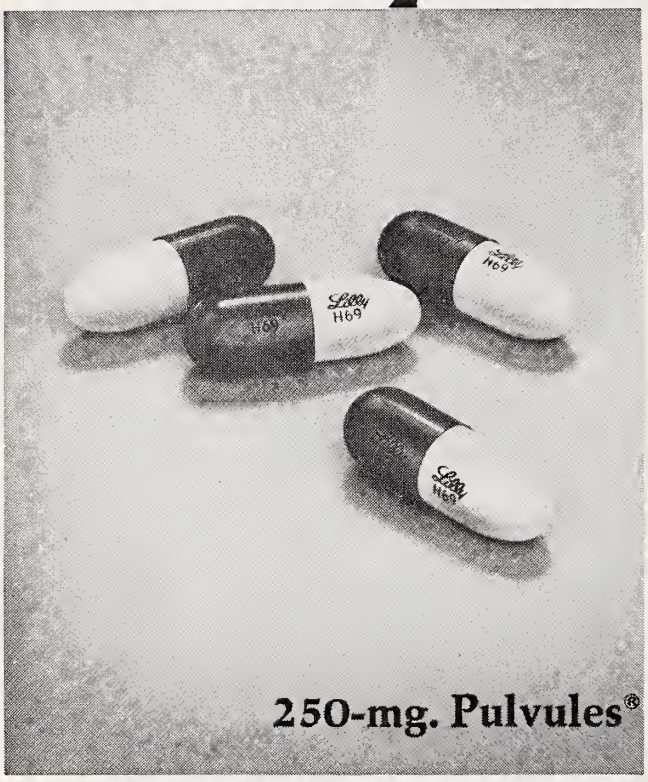
"Rehabilitation is an integral part of the management of the patient with breast cancer. The Society's interest has been successfully expressed primarily through the Reach to Recovery Program which provides psychological, physical and cosmetic rehabilitation to the mastectomy patient. This does not preclude reconstructive efforts in suitable instances.

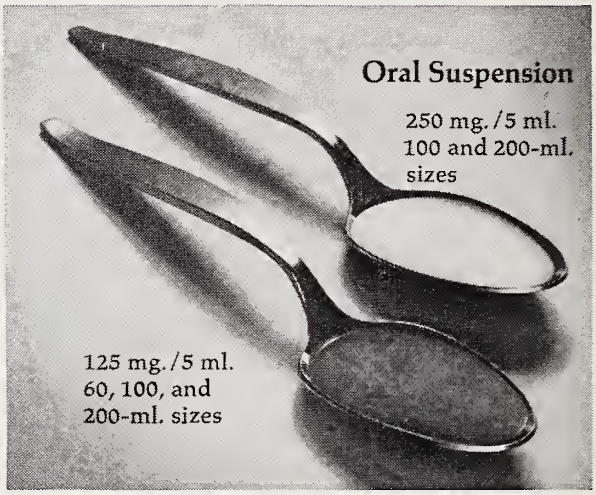
"The basic thrust of the physician should be to improve cure and survival. When this can be accomplished without prejudicing the prospects of physical reconstruction, every effort should be made to preserve a suitable physical base for such restoration.

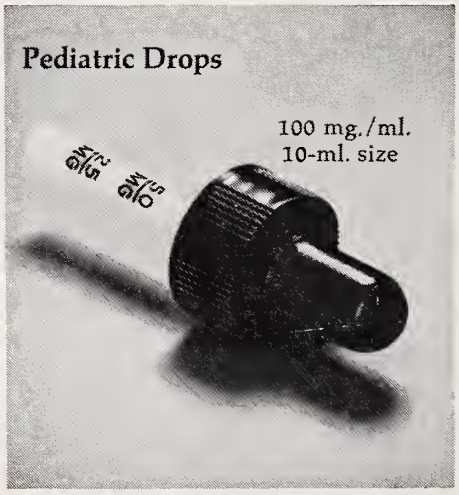
"The Society will continue to expand its educational programs so that both physicians and patients may be aware of the potentials of reconstructive surgery. This does not diminish the importance of the Reach to Recovery Program, but may well serve as an additional measure in appropriate instances to improve the quality of survival.

"It should be understood that many patients are not candidates for reconstructive surgery, and this is fundamentally an issue to be decided by the responsible general surgeon, the patient and the plastic surgeon."

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Cardiovascular Problems in the High Risk Neonate

GEORGE F. ARMSTRONG, M.D., *Columbus**

CARDIOVASCULAR DISEASE, especially critical congenital heart disease, has been recognized as a major cause of cardiorespiratory distress in the newborn. The prompt differentiation between cardiac and pulmonary causes of cardiorespiratory distress may seem relatively simple and clear-cut in term neonates. However, in the high risk infant with multiple problems, the exact role of the cardiovascular disturbance in the overall picture may be difficult to define. The purpose of this article is to discuss briefly four major high risk neonatal problems in which the cardiovascular system plays a major role.

If one excludes patent ductus arteriosus, the incidence of congenital heart disease in the preterm or high risk neonate is no different than in the otherwise normal term infant, i.e. slightly less than one percent. However, the types of defects differ in preterm infants. The most common cardiac defects in preterm infants in order of decreasing frequency are PDA, VSD, coarctation of the aorta, and tetralogy of Fallot. Only the last presents with cyanosis. The more common cyanotic lesions of the newborn (transposition of the great arteries, pulmonary atresia and aortic atresia) are rarely seen in prematures. Therefore, one can conclude that critical, cyanotic congenital heart disease will be unlikely in the preterm infant. In the term infant where pulmonary disease is far less common, critical congenital heart disease must be considered as a likely cause of neonatal cardiorespiratory distress. Prompt and expeditious referral to a newborn cardiac center is essential for the survival of many of the latter group.

One must keep in mind the marked increase infrequency of cardiac defects in newborns (not necessarily premature) with specific syndromes. The increased incidence of cardiac defects in infants with chromosomal abnormalities is well recognized. Approximately 50% of children with Down's syndrome and greater than 95% of those with Trisomy E have major cardiac defects. Genetic influences (family history of congenital heart disease) and environmental terratogens (e.g., fetal alcohol syndrome) both result in an increased incidence of congenital heart defects.

Although many forms of congenital heart disease are infrequently encountered in premature infants, patent ductus arteriosus and the problems associated with this condition may seriously threaten the survival of sick preterm neonates. It has been estimated that 45% of neonates weighing less than 1750 grams and 80% of those weighing less than 1200 grams have persistent patency of the ductus arteriosus.

* Chief of Pediatrics, Medical Center, Columbus. Dr. Armstrong's address is P.O. Box 95L, Columbus, Ga. 31902.

Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd , NE, Atlanta, Ga. 30324.

Histologically the ductus arteriosus has spirally arranged smooth muscle cells forming the media rather than elastic tissue as in the aorta. The intima is four to five times thicker in the ductus arteriosus than in the aorta. In the term infant at birth, the increased arterial pO_2 and the decrease in local production of prostaglandin E_1 produce contraction of the spiral muscle fibers with resultant shortening of the ductus and obliteration of its lumen by the build-up of thickened intima. The functional closure of the ductus occurs within the first 18 hours after birth and is converted to permanent anatomic closure within several weeks.

The ductus arteriosus in the premature infant is relatively insensitive to oxygen, and local prostaglandin production may be increased. Respiratory distress syndrome is common during the first few days of life, and the pulmonary arteriolar resistance remains elevated. However, as the RDS improves and pulmonary resistance falls, left-to-right shunting begins. With increasing pulmonary flow permeability of the fragile capillaries increases, and pulmonary edema ensues. Clinically this process is manifest by decreasing lung compliance, rising $paCO_2$ and falling paO_2, and inability to wean the infant from respirator support. Murmurs may or may not be audible, although the precordium becomes noticeable hyperdynamic. Electrocardiograms are not helpful, and often the radiologist will be unable to differentiate between the radiologic appearance of shunt disease and hyaline membrane disease. Echocardiography is especially helpful in evaluating left atrial size which correlates well with the size of the left-to-right shunt.

Initial management of the patent ductus arteriosus complicating the recovery of the premature neonate with RDS is aimed at reducing intra- and extravascular volume. Fluid restriction and the administration of rapid-acting diuretics such as Furosemide are very effective. Since myocardial dysfunction is not a major component of the problem, digitalis may be of little benefit. When medical management fails to produce rapid improvement, surgical ligation must be considered. Pharmacologic closure of the PDA with the use of inhibitors of prostaglandin synthesis such as indomethacin must be considered as an experimental technique at this time.

When pulmonary vascular resistance remains elevated in excess of systemic vascular resistance in the neonate, right-to-left shunting takes place through the ductus arteriosus and the foramen ovale. Severe arterial hypoxemia results. This condition is known as persistent fetal circulation. The elevated pulmonary resistance may be associated with severe pulmonary disease such as hyaline membrane disease or meconium aspiration pneumonia. Sludging may elevate pulmonary resistance in hyperviscosity syndromes. Perinatal asphyxia and acidosis may produce pulmonary arteriolar spasm with the resultant increase in pulmonary resistance.

Persistent fetal circulation should be considered when neonates are hypoxic out of proportion to their degree of pulmonary disease. The paO_2 will often fluctuate wildly as the pulmonary arterioles contract and relax. The diagnosis will be supported by the finding of differential paO_2 between the upper and lower extremities, since the descending aorta receives venous blood shunting right-to-left across the ductus arteriosus. A 10-20% higher paO_2 from a radial artery than from the umbilical artery strongly supports the diagnosis of persistent fetal circulation. Treatment is aimed at maintaining adequate intravascular volume and preventing or treating acidosis as well as the primary pulmonary disease, if present. Alkalinization of the patient by hyperventilation and bicarbonate administration may reduce pulmonary arteriolar spasm but must be used cautiously because of the possibility of intracranial hemorrhage. Tolazoline, an alpha blocking agent, will also relieve pulmonary vasospasm if infused into a scalp vein or directly through a pulmonary arterial catheter.

Unfortunately, a significant number of preterm infants treated for prolonged periods on respirators develop bronchopulmonary dysplasia. This severe form of chronic lung disease in the infant affects the pulmonary arterioles and may lead to cor pulmonale and right heart failure. An enlarging heart in the infant with long standing lung changes should suggest cor pulmonale. EKG's will show increasing

right ventricular hypertrophy and right atrial abnormality. Treatment is often less than satisfactory, but cautious use of digoxin and diuretics should be tried. A significant number of infants with bronchopulmonary dysplasia eventually recover, but the prognosis is very poor in those who develop cor pulmonale.

In summary, the role of cardiovascular disease in the high risk neonate has been reviewed. Congenital heart disease is no more common in preterm neonates than in term newborns but must be considered in all babies with cardiorespiratory distress. Persistent patency of the ductus arterioles often presents a problem, especially in those premature babies recovering from severe hyaline membrane disease. Persistent fetal circulation or persistent pulmonary artery hypertension may be a part of or the sole cause of cardiorespiratory distress in the high risk neonate. Finally, cor pulmonale may occur in the infant with bronchopulmonary dysplasia and carries a very poor prognosis.

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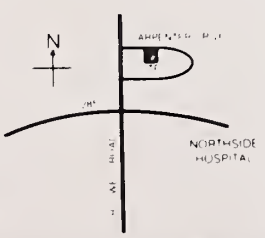
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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 1 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

VRD PD-JA-1699-2-P (8-76)

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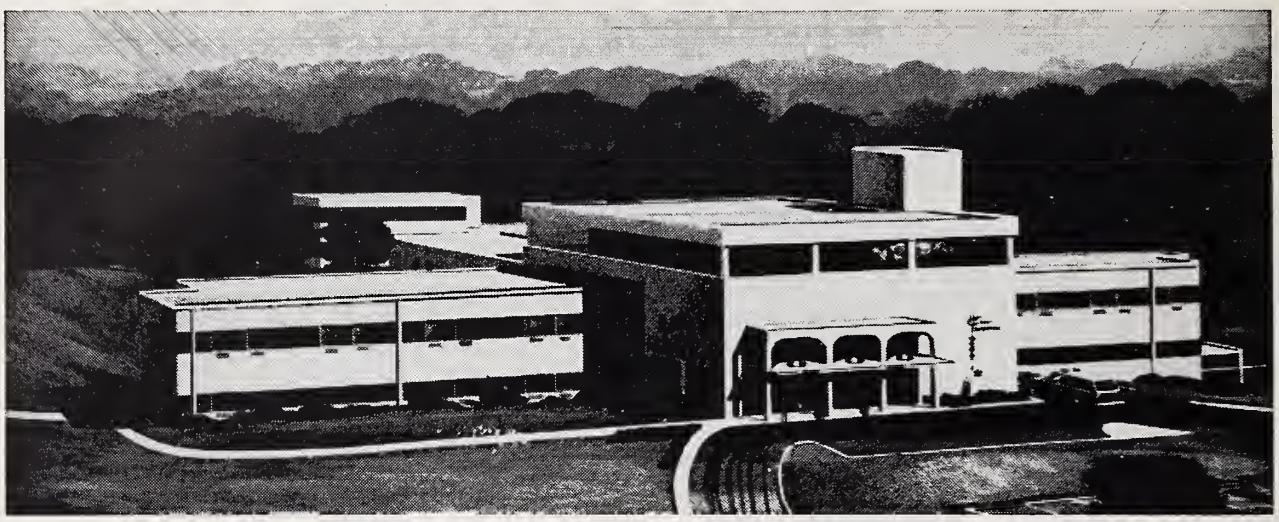


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Recent Developments: Medicare-Medicaid Anti-Fraud and Abuse Amendments; Disclosure of PSRO Information

ROBERT N. BERG, *Atlanta**

THE DEPARTMENT OF HEALTH, Education and Welfare (HEW) recently proposed regulations implementing the "disclosure of information" provisions of the "Medicare-Medicaid Anti-Fraud and Abuse Amendment." In addition, legislation was recently introduced in Congress for the purpose of insuring that Professional Standards Review Organizations (PSROs) will not be subject to the full range of information disclosure requirements of the Freedom of Information Act; this legislation is in direct response to the decision by the United States District Court for the District of Columbia that a PSRO is an "agency" within the meaning of the Freedom of Information Act. Consequently, this appears to be an opportune time to update the *Journal* articles dealing with these two topics[1] in light of these recent developments.

Proposed HEW Regulations

The "Medicare-Medicaid Anti-Fraud and Abuse Amendments" (the "Amendments")[2] were adopted for the purpose of strengthening the capability of the government to detect, prosecute and punish fraudulent activities under the Medicare and Medicaid programs. In that context, the Amendments focused on five major areas: (1) strengthened program penalty sanctions; (2) increased disclosure of information; (3) needed improvements in the Professional Standards Review program; (4) administrative reform; and (5) technical revision.

The proposed HEW regulations (the "Regulations") implement the second major focal point of the Amendments, the disclosure of information provisions. Pursuant to the Regulations, certain specified agencies and institutions (denoted as "disclosing entities") are required to disclose, on a routine basis and as a condition precedent to their participation in the Medicare and Medicaid programs, specific

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, Ga. 30303.

ownership and related information; moreover, these disclosing entities are also required to disclose information both as to certain business transactions conducted between the disclosing entity and specified related parties, and as to certain persons convicted of program-related criminal offenses.

Initially, the Regulations provide that certain specified entities are required to disclose ownership and related information; in that context, the Regulations define a "disclosing entity" as including: (1) Medicare providers, including hospitals, skilled nursing homes, clinical laboratories, renal disease facilities, and health maintenance organizations; (2) entities (other than practitioners or groups of practitioners) that furnish services, or arrange for furnishing services, under Medicaid, the Maternal and Child Health and Crippled Children's Services (MCH-CC) and the Social Services programs; and (3) fiscal intermediaries, fiscal agents and carriers participating in the Medicare and Medicaid programs.[3]

Pursuant to the Regulations, a disclosing entity is required to disclose the name of any person having any of three distinct types of ownership interests in that entity: (1) direct ownership or control; (2) indirect ownership or control; and (3) common ownership. Initially, the Regulations define a person with a direct ownership or control interest as one owning a five percent or greater interest in the disclosing entity, owning a five percent or greater interest in a mortgage or other obligation secured in whole or in part by the entity, being an officer or director of the disclosing entity if that entity is a corporation, or being a partner in the disclosing entity if that entity is a partnership.[4]

A disclosing entity is also required to disclose the name of any person having an "indirect ownership interest" in that entity. For purposes of this disclosure requirement, the Regulations define an "indirect ownership interest" as any ownership interest in an entity that has an ownership interest in the disclosing entity; moreover, the Regulations state that an "indirect ownership interest" includes an ownership interest in an entity that has an "indirect ownership interest" in the disclosing entity.[5] For example, a disclosing entity would be required to disclose the name of a person who had an ownership interest in Company A, if Company A had an ownership interest in Company B, and Company B had an ownership interest in the disclosing entity.[6] The application of this definition is limited, however, in that the Regulations provide that only those persons with "indirect ownership interests" which are the equivalent of a five percent or more direct ownership interest must be disclosed by the disclosing entity.

In addition to disclosing the names of those persons having either direct or indirect ownership interests in a disclosing entity, the entity is also required to disclose, to the extent feasible, whether or not any of the persons it has identified as having an ownership or control interest have an ownership or control interest in another disclosing entity. In light of the difficulty inherent in obtaining this cross-ownership information, however, the Regulations provide that an entity will satisfy this requirement if it provides cross-ownership information "to the extent that it can obtain (such information) by making a written request of those people having an ownership or control interest in the entity."[7]

The Regulations also require that a disclosing entity identify any subcontractor in which that entity has a direct or indirect ownership interest of five percent or more. A "subcontractor" is defined as an individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities for providing medical care to its patients or some of its responsibilities as a fiscal intermediary or agent; thus, an independent radiological service or a management company with which a disclosing entity has contracted to administer either all or a part of its day-to-day operations would be a "subcontractor" and would have to be identified by the disclosing entity.[8]

Moreover, a health care provider under the Medicare, Medicaid and Social Services programs is required to provide, upon request by the Secretary of HEW or by an appropriate State agency, ownership information on any subcontractor with whom the provider has had more than $25,000 in business transactions during the

previous twelve months and information on any "significant business transactions" occurring during the previous five years between the provider and either a subcontractor or a wholly-owned supplier.[9]

Finally, the Regulations require, as a condition of participation in the Medicare, Medicaid or Social Services programs, that disclosing entities submit to the Secretary of HEW or to an appropriate State agency the name of any person having an ownership interest in the entity or any director, officer, agent or managing employee of that entity who has been convicted of a program-related criminal offense. This information must be routinely submitted by the disclosing entity, and the failure to do so will result in the denial or revocation of the entity's program agreement. More importantly, however, disclosure by an entity of the fact that an owner, officer, director, agent or managing employee of that entity has been convicted of a program-related crime may also result in the denial or revocation of the entity's program agreement, although the final decision is left to the discretion of the Secretary of HEW.[10]

PSRO Legislation Introduced

In *Public Citizen Health Research Group v. Department of Health, Education and Welfare,*[11] the United States District Court for the District of Columbia held that a PSRO was an "agency" within the terms of the Freedom on Information Act (the "Disclosure Act")[12] and was therefore subject to the disclosure requirements contained in the Disclosure Act. Although the Court did not specifically hold that any PSRO data or information were required to be disclosed, the Court's decision raised the spectre of the general availability of PSRO records in the future to the public by means of the Disclosure Act.[13] The Court itself recognized this possibility, but stated that the remedy for alleviating this problem lay with Congress, not with the Courts.

Accepting this challenge, Representatives Tim Lee Carter and Paul Rogers have introduced legislation in the House of Representatives which would specifically exempt PSRO's from the terms of the Disclosure Act.[14] The legislation, aimed at preserving a PSRO's ability to utilize and have access to patient data and information and insuring that such data and information would remain confidential, has been referred to the House Committees on Ways and Means and Interstate and Foreign Commerce.

Notes

1. See, Vincent and Berg: "Medicare-Medicaid Anti-Fraud and Anti-Fraud and Abuse Amendments," *Journal of the Medical Association of Georgia,* Volume 66, No. 12 at 973-974 (December, 1977); Berg: "Release of PSRO Data to the Public under Federal Law," *Journal of the Medical Association of Georgia,* Volume 67, No. 8 at 663-667 (August, 1978).
2. Public Law 95-142 (1977).
3. 45 C.F.R. §405.603-0(b)(2)(i)-(iv).
4. 45 C.F.R. §405.603-0(b)(9), (11) (i)-(v).
5. 45 C.F.R. §405.603-0(b)(10).
6. This somewhat confusing definition is apparently the result of and necessitated by Congress' concern over the problem of "pyramiding," whereby a person could circumvent the disclosure requirements by placing several corporations between himself and the disclosing entity. The Regulations eliminate this problem by requiring a disclosing entity to "trace ownership interests through the pyramid" and thus disclose the names of its true owners.
7. 45 C.F.R. §405.603-3(a)(2).
8. 45 C.F.R. §§405.603-0(b)(5), 405.603-3(a)(1).
9. Pursuant to the Regulations, a "significant business transaction" is defined as any transaction or series of transactions that, during any fiscal year, exceeds the lesser of $25,000 or five percent of the total operating expenses of the provider. 45 C.F.R. §405.603-0(b)(8).
10. 45 C.F.R. §405.603-2.
11. U.S. District Court, District of Columbia, Civ. No. 77-2093 (April 25, 1978).
12. 5 U.S.C. §552.
13. The Court itself stated that "(we) are well aware that the . . . PSRO program will experience a severe setback, if not fatal blow, should PSRO records become generally available through the (Disclosure Act)."
14. H.R. 13431. Counterpart legislation has been introduced in the Senate by Senator Richard Schweiker (S. 3196), and has been referred to the Senate Finance Committee.



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Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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8-3921 (Y587A)

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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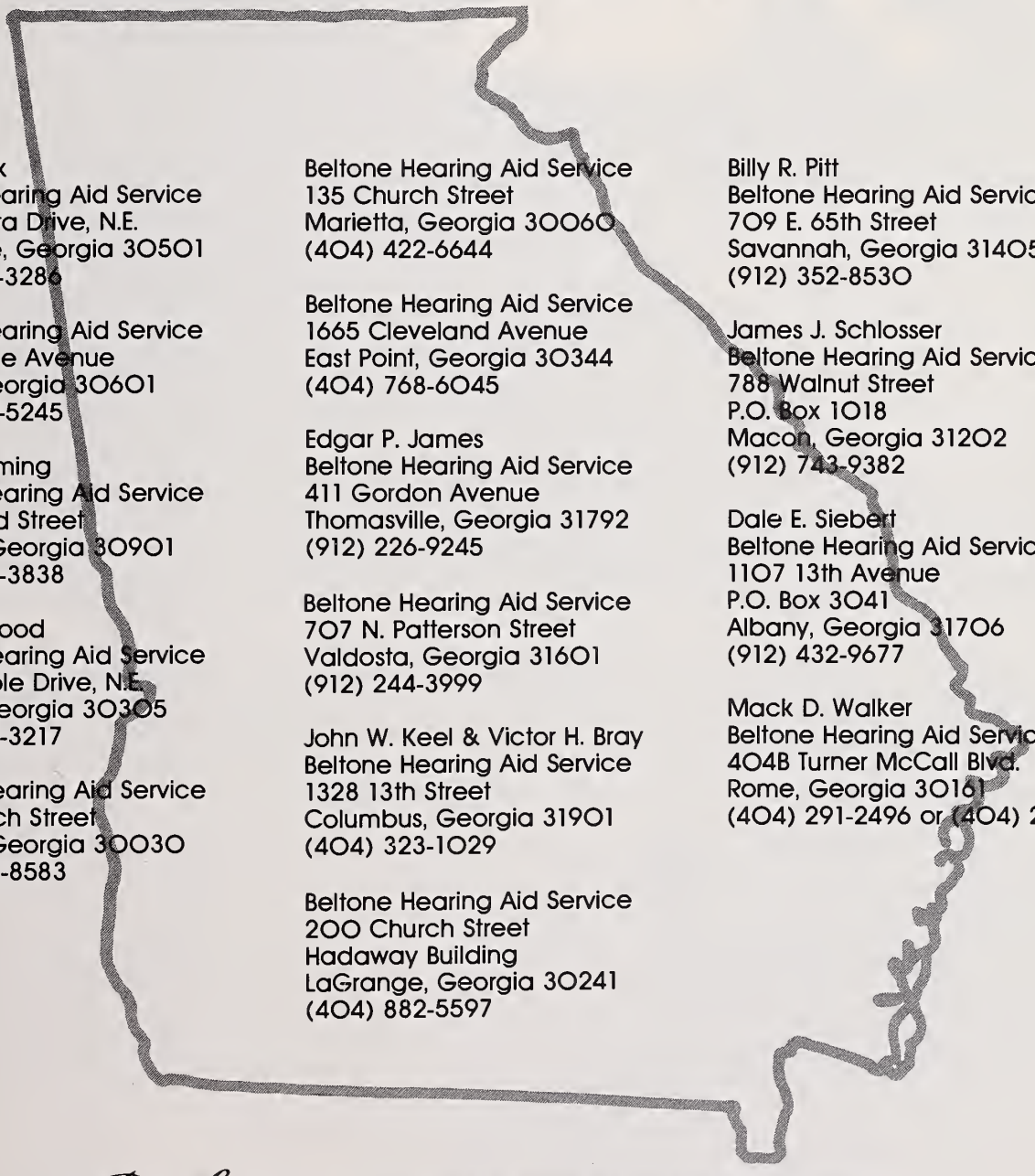
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NEW MEMBERS

Ayers, William Theodore Jr., Troup—N2—GS
Clark-Holder Clinic, 303 Smith St., LaGrange 30240

Boyd, Glenn H., Whitfield-Murray—N2—IM
1217 Memorial Dr., Dalton 30702

Braswell, Harold Morris, Mitchell—S—AM
Mitchell County Hospital, P.O. Box 469, Camilla 31730

Brody, Harold J., MAA—N2—D
478 Peachtree St., NE, Ste 711-A, Atlanta 30308

Georgi, Emil B., Ocmulgee—N2—PTH
Dodge County Hospital, Eastman 31023

Harris, Herbert W. Jr., Dougherty—ACT—D
426 Second Ave., Albany 31701

Isaacson, Ronald, Ga. Med. Soc.—ACT—GS
5102 Paulsen St., #2, Savannah 31405

Kitchens, George Gray, Dougherty—N2—OTO
804 14th Ave., Albany 31701

Levine, Marshall R., MAA—N2—IM
2045 Peachtree Rd., NE, Ste 425, Atlanta 30309

Lewis, Myron Keith, Ocmulgee—N2—IM
Pulaski Professional Bldg., Hawkinsville 31036

Mazzara, Sauveur Vincent, DeKalb—N2—GS
3596 Chamblee Tucker Rd., Chamblee 30341

Nash, Michael Lawrence, Ga. Med. Soc.—N2—IM
Paulsen & 67th Sts., Savannah 31403

Ordonez, Carlos, MAA—ACT—R
1170 Cleveland Ave., East Point 30344

Pope, James Chandler, Carroll-Douglas-Haralson—N2—CDS
619 Dixie St., Carrollton 30117

Ray, James Leon, Emanuel—N2—FP
P.O. Box 387, Swainsboro 30401

Ross, Millard I., Newton-Rockdale—N2—GS
2192-B Salem Rd., Fieldstone Mall, Conyers 30207

Schultz, Robert M., MAA—N2—PD
993 Johnson Ferry Rd., Ste 335, Atlanta 30342

Siegel, Donald, DeKalb—ACT—GS
755 Columbus Dr., Ste 717, Decatur 30030

Whitmire, Ronald Norman, Hall—N2—OTO
435 Spring St., Gainesville 30501

Yu, Cheng Ling, DeKalb—ACT—OBG
365 Winn Way, Ste 100, Decatur 30030

SOCIETIES

The first of three public forums on heart disease, presented by the **Cobb County Medical Society,** was held September 12. The other two are scheduled for October 10 and November 14.

PERSONALS

First District

H. R. Frost, M.D., Swainsboro, completed CME requirements to retain active membership in the American Academy of Family Physicians.

Third District

Columbus physician **Wallace E. Griner, M.D.,** has been elected vice president of the Georgia Chapter of the American College of Emergency Physicians. Dr. Griner is chief of emergency services at the Medical Center and has been on the group's board of directors five years.

Walter W. Simpson, M.D., was elected to the board of the Georgia Chapter of the American College of Emergency Physicians.

Fifth District

Atlanta physician **Edwin C. Evans, M.D.,** has been elected for a five-year term to the Institute of Medicine of the National Academy of Sciences. He is one of only 27 physicians chosen from throughout the United States.

Professor and chairman of the Department of Medicine at Emory University's School of Medicine, **J. Willis Hurst, M.D.,** has been chosen a recipient of the 1978 Award for Distinguished Achievement given by *Modern Medicine* magazine. One of 11 U.S. physicians receiving the honor this year, Dr. Hurst was cited "for combining in his own career the roles of educator, administrator, and practitioner, and for performing each at the highest level of excellence." The magazine said, "Few figures have had as strong an impact on American medical education as Dr. Hurst." Winners of the awards were selected by deans of medical schools, leaders of professional organizations, and members of the magazine's editorial boards.

Nanette K. Wenger, M.D., professor of medicine (cardiology) at Emory University's School of Medicine and 1978 president of the Georgia Heart Association, has been chosen Woman of the Year by the National Ladies Auxiliary of the Jewish War Veterans of the U.S.A.

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Sixth District

Dublin physician **R. D. Shuman Jr., M.D.,** had his paper, "Intrathecal Gentamicin for Refractory Gram-Positive Meningitis," published in the August 4, 1978, issue of the *Journal of the American Medical Association.*

Seventh District

James A. Routledge, M.D., Rome has been elected president of the staff of Floyd Medical Center. President-elect is **L. C. Rigas, M.D.**

Redmond Park Hospital, Rome, elected **Joel Todino, M.D.,** president of its medical staff. **Jack Edgens, M.D.,** was made president-elect and **Jim Rogers, M.D.,** was elected secretary.

Eighth District

W. B. Bates Jr., M.D., Waycross, has completed CME requirements to retain active membership in the American Academy of Family Physicians.

Brunswick physician **Jesse L. Hunt, M.D.,** has been elected president of the Georgia Chapter of the American College of Emergency Physicians.

DEATHS

Samuel B. Chyatte

Samuel B. Chyatte, M.D., Atlanta, died July 30 at the age of 42.

A professor of allied health services at Emory, he was project director of the Emory University Regional Rehabilitation Research and Training Center. Prior to his appointment as project director in July 1977, he had served as the center's director of training.

Dr. Chyatte was a member of the Georgia Composite State Board of Medical Examiners and was also on the Physical Medicine and Rehabilitation Board.

A native of New York City, he graduated cum laude from Lehigh University and was a graduate of the Jefferson Medical College in Philadelphia.

He had served as chief of the department of physical medicine at Emory Hospital, as a visiting staff member of the Grady Memorial Hospital, and as a staff member of both Wesley Woods Health Center and the Henrietta Egleston Hospital for Children.

Survivors include his widow, two daughters, two sons, a brother.

John Ross McCain

John Ross McCain, M.D., Decatur, died July 20 at the age of 63.

At the time of his death, he was a professor in the Department of Ob/Gyn, Emory University, head of the Department of Ob/Gyn at Crawford W. Long Memorial Hospital, chairman of the Health Care Commission of the American College of Obstetricians and Gynecologists and that organization's alternate representative to the AMA Interspecialty Advisory Board, and Tenth District director of the Georgia Medical Care Foundation.

A graduate of Emory University School of Medicine, Dr. McCain was commissioner on practice of the American College of Obstetricians and Gynecologists, past second vice president and past chairman of District 4 of the American College of Obstetricians and Gynecologists, past vice chairman and past chairman of the AMA Section Council on Obstetrics-Gynecology, and past president of

the South Atlantic Association of Obstetricians and Gynecologists. He was also past president of the Atlanta, Southeastern, Georgia State and Dan Thompson Obstetric and Gynecological Societies.

Survivors include his wife, Vivienne Long McCain, two daughters, two sons.

William A. Noble

William A. Noble, M.D., Atlanta, died August 4 at the age of 83.

Born in Scotland, Dr. Noble spent his youth in Florida, where he became a registered pharmacist at the age of 16. He later entered the Atlanta School of Medicine and was a member of the first class to graduate from Emory University's Medical Department (1916). He did his internship at the Salvation Army's Booth Memorial Hospital in Covington, Kentucky, and later served in the U.S. Army during WWI.

Commissioned as a colonel in the Salvation Army, he served for 40 years in that organization's Catherine Booth Hospital in Nagercoil, India, building the hospital from 40 inpatients to 500. In 1957, he received the Salvation Army's highest honor, the Order of the Founder.

Dr. Noble officially retired in 1961, but returned to take charge of another hospital in India, where he served an additional 5 years. He then returned to Atlanta, where he became medical consultant to the American Red Cross Blood Unit and medical officer for the Salvation Army's School for Officers' Training.

At age 80, Dr. Noble was asked by the U.S. Department of the Army to assist in giving physicals to recruits, a duty he performed until a few months before his death.

Survivors include his wife, Salvation Army Lt. Colonel Lillian Hansen, a daughter, two sons, seven grandchildren, a sister.

Lewis L. Rawls

Lewis L. Rawls, M.D., Macon, died August 26 at the age of 77.

A native of Laurens County, he lived most of his life in Macon. He was graduated from Oglethorpe University and the University of Georgia Medical School in Augusta and also did graduate work at Harvard Medical School.

Dr. Rawls began his private practice in Macon in the late 1920s.

Survivors include a daughter, two grandsons, three sisters, one brother.

Letters to the Editor

Dear Sir:

I would like to have you add another abbreviation to the Special Glossary you included in the *Journal,* August 1978 edition. AAMA — American Association of Medical Assistants. This is a national organization with over 400 members in Georgia alone. Our headquarters is in Chicago, at One East Wacker. Our main goal is continuing education and patient care. We also offer certification.

Please include this in your listing and I think this glossary is an excellent idea.

If you have any questions concerning our organization please contact me at (404) 256-4760.

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Certified Medical Assistant–Administration
Atlanta

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Noted Educators to Address Scientific Assembly

Dr. William Ruhe, Senior Vice President of the AMA and a major figure in setting national policies in medical education, will be the featured speaker at the MAG Luncheon on Saturday, November 11, at the World Congress Center in Atlanta. The luncheon will kick off MAG's fourth annual Scientific Assembly, and all Assembly-goers and spouses are urged to attend. Dr. Ruhe will describe the shape of the future in medical schools, specialization, licensure, and mandatory continuing medical education in the 1978 Calhoun Lecture — "1984: Nightmare or Utopia for Medical Education?"

This year the Assembly will be a combined effort of the MAG and the Southern Medical Association, with over 3,000 physicians expected to attend. Scientific sessions in all 23 major specialties will run from Saturday morning through Tuesday morning, November 14.

Among the distinguished scientific speakers will be Alejandro Castro, Colon and Rectal Surgery; Richard Schwarz, Obstetrics; Arthur Keeney, Ophthalmology; McCollister Evarts, Orthopedics; Beverly Armstrong, Otolaryngology; Henry Norris, Pathology; Gordon Millichap, Pediatrics; Salvador Castanares, Plastic Surgery; Thomas Ballantine, Psychiatry; Manuel Viamonte, Radiology; James Hardy and C. Rollins Hanlon, Surgery; and William Staubitz, Urology. Speakers in other specialties are listed in the program printed in this issue of *JMAG*.

An extensive educational program for spouses will feature courses on cosmetic surgery, cardiopulmonary resuscitation, finance for women, interior design, antiques, jewelry, gardening, and body language, as well as tours, organized Christmas shopping, and social events. See the complete program in this issue for information on course fees and registration.

The Assembly will be free to all members of the MAG or SMA. Registration fee for non-members is $20. You are invited to fill out the pre-registration form found elsewhere in this issue and mail it to the SMA office in Birmingham. Please note the special fees for postgraduate courses and meal functions, including the MAG Luncheon.

For more information, contact Scientific Assembly at the MAG office, (404) 876-7535, or (toll-free) (800) 282-0224. — **S.L.D.**

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Improved techniques in collections
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The proper path for the spouse to follow through probate . . . wills . . . trusts . . . the estate
On being an executrix
Selling (or dissolving) the practice
Creating cash at the proper time

Registration forms for MAGNET '78, along with hotel reservation cards, have been sent to all MAG members. If you have not registered, please complete the form below and send to: MAGNET '78, 938 Peachtree Street, N.E., Atlanta, Ga. 30309. For hotel reservations, contact the Terrace Garden Inn in Atlanta at (404) 261-9250.

MAGNET '78 REGISTRATION FORM

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MAG Members and their staff **$35.00 each**

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ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Please see brief summary of prescribing information on facing page.

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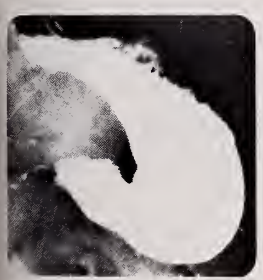
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helps control abnormal motor activity with minimal anticholinergic side effects†

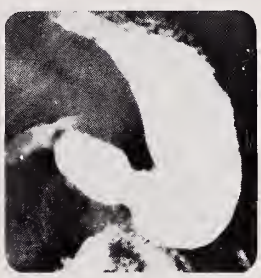
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1976

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Classifieds

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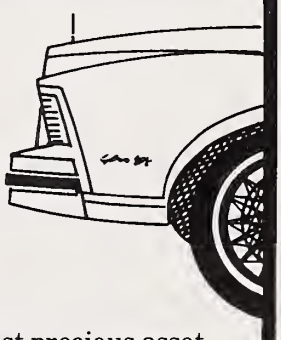
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THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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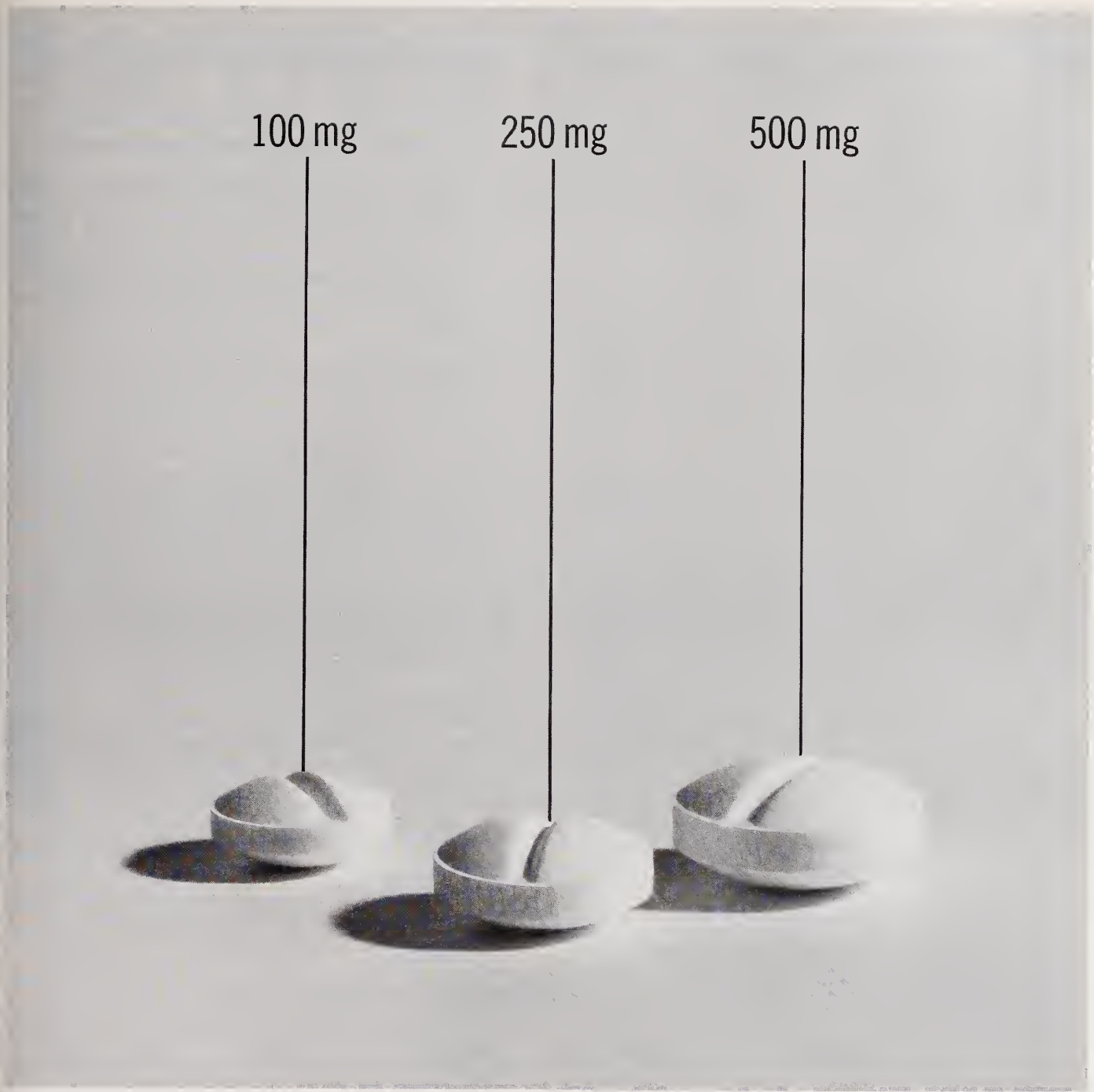
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938 Peachtree Street, NE / Atlanta, Georgia 30309

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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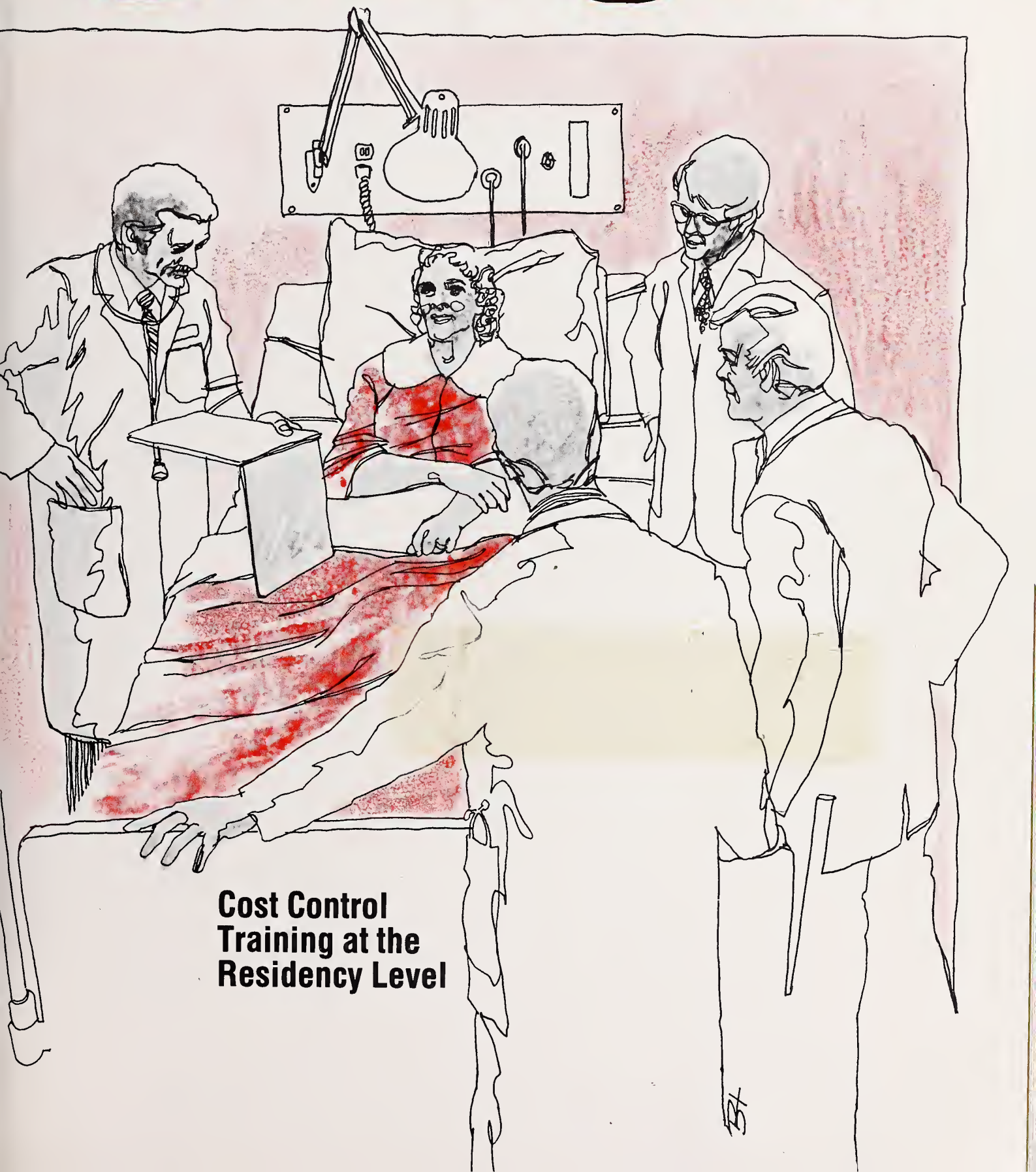
The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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NOVEMBER

29—*Sanford, NC;* **NUTRITION IN MEDICAL CARE 1978;** Contact: R. S. Cline, M.D., Director of CME, Lee County Hospital, Sanford, NC 27330.

29-December 3—*Atlanta;* **THIRD SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ADDICTION;** Contact: Conway Hunter, Jr., M.D., Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd., Atlanta 30338. PH: 404/455-3200.

DECEMBER

1-2—*Charlotte, NC;* **AMERICAN COLLEGE OF PHYSICIANS — NORTH CAROLINA SOCIETY OF INTERNAL MEDICINE ANNUAL MEETING;** Category 1 Credit; Contact: Norman H. Garrett, M.D., 1038 Professional Village, Greensboro, NC 27401.

1-2—*Lexington, KY;* **FIBEROPTIC BRONCHOSCOPY: A WORKSHOP;** Category 1 Credit; Contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506. PH: 606/233-5161.

1-2—*Nashville, TN;* **TENNESSEE REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Blair D. Erb, M.D., F.A.C.P., Jackson Clinic, 616 West Forest, Jackson, TN 38301.

2—*Atlanta;* **WELLNESS CONFERENCE ON NUTRITION, STRESS REDUCTION, PHYSICAL FITNESS, AND SELF RESPONSIBILITY;** Contact: Anita Sanborn, NCGHSA, 1447 Peachtree Rd., N.W., Atlanta 30309. PH: 404/892-5952.

2—*Winston-Salem, NC;* **PREGNANCY, BIRTH, AND INFANCY: ORIGINS OF ATTACHMENT;** Contact: Emery C. Miller, M.D., Associate Dean for CME, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

7-8—*Atlanta;* **CURRENT CONCEPTS IN ANTERIOR SEGMENT SURGERY AND DISEASE;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

7-8—*Augusta;* **FAMILY DYNAMICS;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

7-10—*Las Vegas, NV;* **AMA WINTER SCIENTIFIC PROGRAMS;** Category 1 Credit; Contact: James H. Sammons, M.D., AMA, 535 N. Dearborn St., Chicago, IL 60610.

8—*Atlanta;* **FOURTH ANNUAL HOLIDAY INFECTIOUS DISEASES SEMINAR;** Category 1 Credit; Contact: James S. Maughon, M.D., 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211.

9-11—*St. Petersburg, FL;* **FIFTH ANNUAL SYMPOSIUM ON THE TREATMENT OF SEXUAL PROBLEMS;** Category 1 Credit; Contact: Bill Rockwood, Program Coordinator, University of Florida College of Medicine, Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610. PH: 904/392-3143.

10-15—*Lexington, KY;* **NINTH FAMILY MEDICINE REVIEW, SESSION III;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506.

11-12—*Jacksonville, FL;* **LAPAROSCOPY COURSE;** Contact: Robert J. Thompson, M.D., 655 West 8th St., Jacksonville, FL 32209.

11-15—*Chapel Hill, NC;* **INDUSTRIAL TOXICOLOGY;** Contact: Mario Battigelli, M.D., Department of Medicine, UNC School of Medicine, Chapel Hill, NC 27514.

13—*Greenville, NC;* **OFFICE GYNECOLOGY;** Category 1 Credit; Contact: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville, NC 27834.

JANUARY

6-13—*Caribbean Sea;* **CURRENT TOPICS IN PEDIATRICS;** Contact: Judson Hawk, M.D., Scottish Rite Hospital, 1001 Johnson Ferry Rd., Atlanta 30342. PH: 404/256-5252.

10—*Greenville, NC;* **IMMUNOLOGICAL ASPECTS OF MALIGNANCY;** Category 1 Credit; Contact: F. M. Simmons Patterson, M.D., Assistant Dean for Continuing Education, East Carolina University School of Medicine, Greenville, NC 27834.

17-19—*Atlanta;* **VOCATIONAL IMPLICATIONS FOR THE CANCER DISABLED;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

18-20—*New Orleans, LA;* **ALLIANCE FOR CONTINUING MEDICAL EDUCATION 1979 ANNUAL CONFERENCE;** Contact: ACME, Miller Communications Inc., 322 Westport Ave., Norwalk, CT 06851.

18-20—*Lake Buena Vista, FL;* **CARDIOVASCULAR SEMINAR FOR CRITICAL CARE PERSONNEL;** Category 1 Credit; Contact: Bill Rockwood, Coordinator, University of Florida College of Medicine, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610.

19—*Atlanta;* **NEONATAL SEMINAR;** Contact: Atlanta Lung Association, Inc., 723 Piedmont Ave., Atlanta 30308. PH: 404/872-9653.

26-27—*Winston-Salem, NC;* **CLINICAL UROLOGY;** Contact: Emery C. Miller, M.D., Associate Dean for CME, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

29-February 3—*Aspen, CO;* **THIRD ANNUAL EMORY CONFERENCE ON PAIN;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

30—*Atlanta;* **TEAM BUILDING — A BETTER WAY TO SUPERVISE (WORKSHOP FOR OFFICE MANAGERS);** Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

31-February 1—*Atlanta;* **STARTING YOUR PRACTICE (WORKSHOP FOR RESIDENTS);** Category 1 Credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

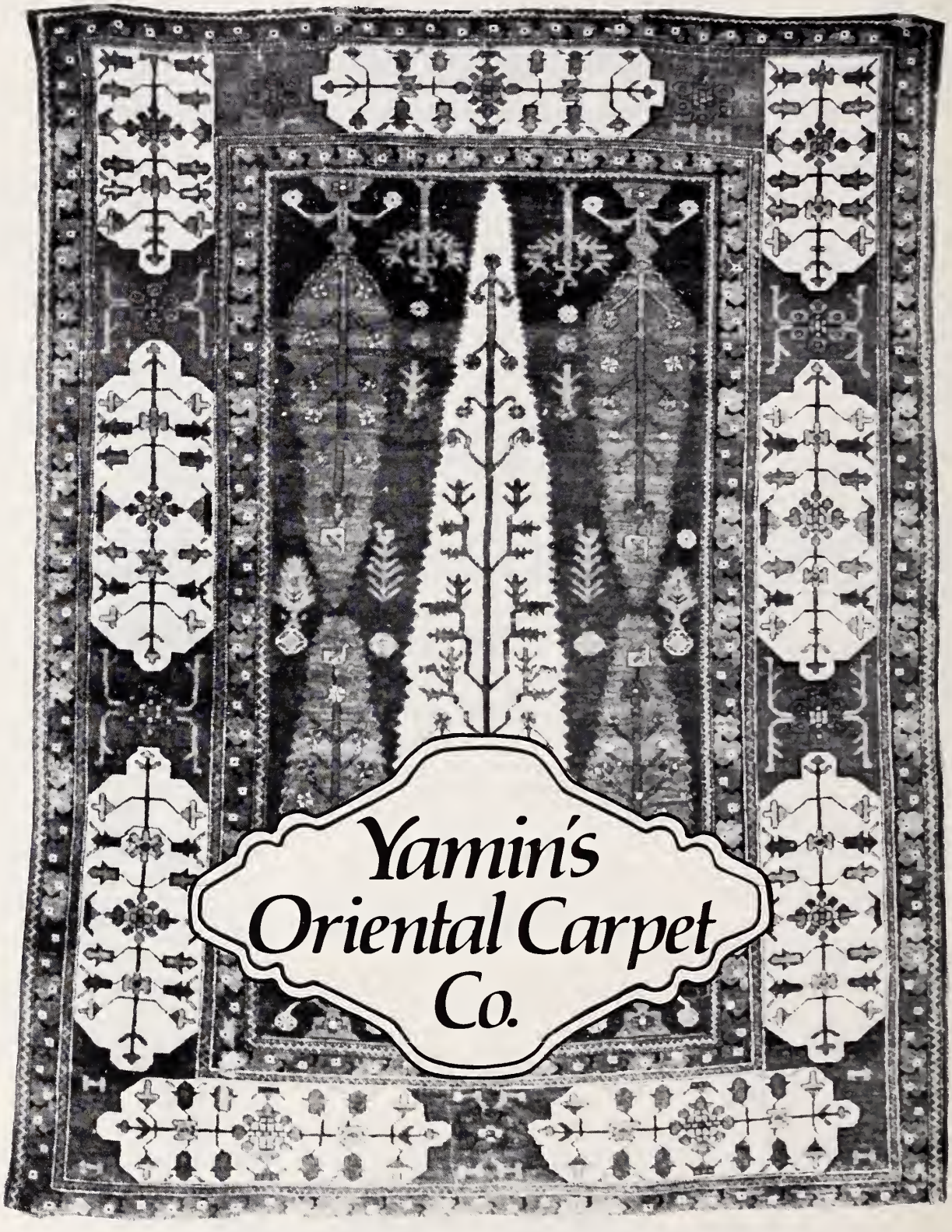
FEBRUARY

1-3—*Chapel Hill, NC;* **WOMACK SURGICAL SOCIETY MEETING;** Contact: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill, NC 27514.

5-7—*Atlanta;* **ANNUAL MATERNAL-FETAL POSTGRADUATE CONFERENCE;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

8-9—*Augusta;* **CLINICAL PSYCHIATRY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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Letters to the Editor . . .

Error Noted

Dear Sir:

I wish to take exception with you concerning your editorial on Physician's Assistants in the August issue of the *Journal of the Medical Association of Georgia*.

You stated that the Medical College of Georgia had 128 students and that the Medical College will graduate 61 students this year. Doubting these figures, I checked with the Physician's Assistant Department of Georgia Medical College and they will graduate 23 Physician's Assistants this year. They have 24 moving up to the Senior Class after finishing their junior year, which is the first year in Physician's Assistant School. There will be 24 admissions this Fall in the Freshman Class.

Your figures give the impression that Physician's Assistants are flooding the market. I have employed two Physician's Assistants for the past two years. I have found them to be a valuable asset to me and my practice of medicine in my location of 7500 population with a drawing radius of some 60 miles.

The policy adopted by the Medical Association of Georgia at its last meeting does not reflect the feeling of the entire membership.

The Physician's Assistant Program was initiated by the Georgia Legislature to provide rural health care. This is being done by more and more physicians in the smaller areas, by employing physician's assistants.

Hope you will clarify your August remarks in the next *Journal* issue.

H. W. Smith, M.D.
Swainsboro

(Editor's Response: Your figures are correct. The number I erroneously reported represented the combined number of graduates from the Medical College of Georgia (MCG) and from Emory. The correct breakdown is 23 from MCG and 38 from Emory, for a total of 61. Thank you for calling this error to my attention.)

Reaction to September Issue

Dear Sir:

I am writing in regard to your September 1978 edition. As I rarely write a letter to the editor, I will try to be as concise as possible. On page 713, a Dr. Cohen made a comment about cost containment. He refers to a history, physical and ECG of being $50.00. I am extremely amazed that this physician would compare this fee, which I personally think is quite low, to a fee that a radiologist charges ($65.00) for interpreting a brain scan.

I do not think it requires a great length of time to interpret a brain scan, but I think a comprehensive history and physical would take at least an hour. I wonder how Dr. Cohen can put this down as cost containment and not mention the surgical sub-specialties and especially the interpretation of a brain scan at the charge of $65.00.

Again, it goes to show that the two primary care physicians, the pediatrician and the internist, still are the lowest paid specialties, even though we go to school as long as the surgeons or other sub-specialties. In my opinion, we have a much different type of role in the practice of medicine.

I hope Dr. Cohen in the future comments on some of the surgical fees.

Francis W. Coleman, M.D.
Valdosta

We invite your response to the *Journal*

Send your letters to:

The Editor
Journal of MAG
938 Peachtree St., NE
Atlanta, GA 30309

MAG Poll on Smoking

Pursuant to a 1977 MAG House of Delegates decision urging physicians to assume leadership in eliminating or reducing smoking in all health-related facilities, the 1978 House of Delegates directed that a poll be taken of the MAG membership to determine the effectiveness of this anti-smoking campaign.

If you have not already answered the following questions as they appeared in the October MAG newsletter, please take a minute to do so now and return your response to the MAG office, 938 Peachtree St., N.E., Atlanta 30309. Your cooperation is greatly appreciated.

Are you aware of MAG's position on smoking in medically-related facilities? yes ___ no ___

Do you allow smoking in your office? yes ___ no ___

Have you personally tried to get support for policies which would reduce smoking in your hospital or medical facility? yes ___ no ___

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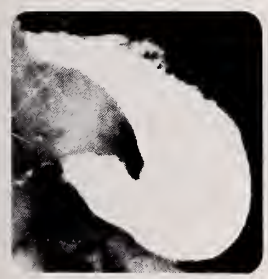
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary
INOICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULO BE NOTEO AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC ORUGS AID IN THE HEALING OF A PEPTIC ULCER, OECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL OISORDERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Oo not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
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JOURNAL
of the medical association of
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Teaching Cost Containment to Medical House Staff

J. WILLIS HURST, M.D., *Atlanta**

MEDICAL INSTITUTIONS are making every effort to deliver excellent patient care as economically as possible. Those of us at teaching institutions have a particular responsibility in this regard, since we have the responsibility of teaching house officers that they must deliver excellent patient care and, at the same time, not waste a single dollar.

To this end, we stress the following as part of our instruction:

(1) Emphasize that excellent medical care does not always mean that it is the most expensive and that expensive medical care does not guarantee excellent patient care.

(2) Emphasize that all physicians must learn the limitations of diagnostic procedures, as well as their value. This means that the sensitivity, specificity, and predictive value of a given test must be known.

Very few physicians enjoy statistics, but a good understanding of mathematics involved in determining the sensitivity, specificity, and predictive value of a procedure is essential if the physician is to save time and money. Such an understanding will prevent the physician from ordering a test that has little diagnostic value in a particular circumstance. The understanding of *Bayes rule* is equally important:

. . . the probability of a given disease (e.g., coronary heart disease) depends upon the probability of the disease giving a particular finding or combination of findings (e.g., substernal chest pain plus coronary calcification), the probability of the finding being present in those with disease, and the prevalence of the disease in the particular population being studied. For example, one cannot assign the same significance to a positive electrocardiogram (ECG) exercise stress test recorded from a young woman as one does to a positive test recorded from a man.

Medical institutions have a responsibility to teach cost control to house officers.

After considering the preceding features of a test, one must be prepared to defend the value of the test in decision making. A test should not be done, even if it is sensitive or specific, if another test which is ordered in the same patient is more sensitive or specific. We tend to use the most recently devised test, one said to be superior in value to all other tests, and yet we may continue to use the older tests that the new test should have replaced.

The division of tests into invasive and noninvasive has its drawbacks. If a noninvasive test is done simply because it is noninvasive, and the results

* Dr. Hurst is a professor of medicine (cardiology) and Chairman of the Department of Medicine at Emory University School of Medicine. His address is 69 Butler St., SE, Atlanta, Georgia 30303.

cannot be used to make a definitive medical decision, then the money the test costs is wasted if an invasive test is needed to make a definite decision. Obviously, if the result of a noninvasive test will give a result on which a definitive decision can be made, it is usually preferable to an invasive test.

When properly used, the problem-oriented system assures one that the appropriate data are gathered from the patient.

(3) Emphasize the criteria needed to make a diagnosis. A physician may know a great deal about a condition but may not know the abnormalities that must be present in order to label the condition as X. At times, more data are collected than are needed and at other times, the data actually needed to accomplish the goal may be insufficient. This problem is not necessarily the physician's fault, since clinical research and the content of textbooks are only now being addressed to this subject.

(4) Emphasize the details of the problem-oriented system. The problem-oriented records (which is one part of the system) enables one to assess the quality of medical care. When properly used, the problem-oriented system assures one that the appropriate data are gathered from the patient. Each item, be it a question, a part of the physical examination, or laboratory test that is done initially must be justified as being needed in order to detect illness in the population of patients seen by the physician. This is known as a *Defined Data Base*.[1] It should enable a physician to identify (a) certain diagnoses (highly resolved problems) and (b) certain conditions that cannot be labeled as diagnoses but are simply poorly resolved problems. These problems are listed on a sheet of paper which is placed in the front of the record (Problem List). *Initial Plans* are then constructed for each problem. One should recall that all problems do not require solution (i.e., slight anemia in a patient dying of cancer of the pancreas). The initial plans for each problem consists of further diagnostic plans, therapeutic plans, and patient education plans. This leads a physician to carefully consider each order in the light of the problem for which it was written and makes it possible for attending physicians to quickly check the appropriateness of the order. The cost of the test must be considered, along with the need for the test and whether or not a definite decision can be made from the results. For example, serum cardiac enzymes may not be needed to diagnose myocardial infarction if the chest pain experienced by the patient is typical and the ECG shows acceptable QRS, or ST and T wave change. The appropriate follow-up of each problem (Progress Note) should be carefully planned in an effort to order what is needed as time passes. Not a single unjustified item should be ordered. More research is needed in this area also. For example, how often should sigmoidoscopy be performed in a patient who has had a colon polyp removed? How often should an ECG be recorded in a patient who has recovered from a myocardial infarction?

(5) Emphasize that academic medicine can be performed anywhere. Academic medicine is not the use of unnecessary tests and procedures. Academic medicine, as I define it, is determined by the quality of the thought process. It can be delivered in every doctor's office and every hospital. It implies that physicians know what is needed for the problems at hand, that they do not order more than that, and that they think more than they order.

(6) Give the house officers the cost of tests and procedures. They are always astounded. Have the house officers estimate the cost of the hospitalization or outpatient visit of a patient they have managed.

(7) Develop a conference in conjunction with the department of pathology where the objective is to discuss the value and limitation of laboratory tests along with the cost of the tests.

(8) Develop a committee of faculty and house staff that is charged with the responsibility of cutting the cost of medical care without sacrificing the quality of medical care.

Academic medicine . . . is determined by the quality of the thought process.

(9) Meet with the house officers each week to discuss the cost of medical care.

(10) Solicit the help of the faculty who supervise the house staff (for example, the chief medical residents at Grady Hospital, Emory University Hospital, Crawford W. Long Hospital, and the Veterans Administration Hospital) and all other physicians who come in contact with the house officers to point out by their actions and words that the inappropriate ordering of drugs, procedures, and follow-up visits wastes money and that we must make every effort to give excellent medical care as inexpensively as possible.

Modern house officers are smart and perceptive. They are clearly doing their part in decreasing the cost of medical care without sacrificing excellence in patient care.

Reference

1. Hurst JW, Walker KL (Eds): The problem-oriented system, Medcom Press, New York, 1972.



Figure 1 — (l. to r.) Drs. Carson B. Burgstiner, H. Duane Blair, Harrison Rogers, and C. Willard Camalier answer questions at a press conference.

Capsule of the Cost Effective Health Care Conference

H. DUANE BLAIR, M.D., *Decatur**

On August 26, 1978, a multi-disciplinary group sponsored by the Medical Association of Georgia met in Atlanta to examine rising health care costs and to identify ways to curb them. Representatives from the American Hospital Association (AHA), the American Medical Association (AMA), the National Education Association (NEA), the Health Insurance Association of America (HIAA), Goodyear Tire and Rubber Company, Blue Cross/Blue Shield Association, and the Health Care Finance Administration discussed cost factors and possible solutions that related to each of their specific areas.

Harrison L. Rogers, M.D., of the AMA House of Delegates, served as moderator for the conference. He challenged those assembled to cooperate in their efforts to solve the problems related to cost control and to the deliverance of effective health care, pointing out that no one group could hope to solve the problems alone.

Mr. Dan Barker, Administrator, Crawford Long Hospital, and chairman-elect of the Board of Trustees of the AHA, addressed some problems from the hospital's viewpoint. The voluntary effort program, sponsored by the AMA, the Federation of Hospitals, and the AHA, has as its primary goal the reduction of the rate of percentage increase by 2 points in 1978 and 2 points in 1979. The federal government estimates that between 1978 and 1983, this program will save $31.3 billion. To reach this goal individual hospitals are dealing with such problems as excess hospital beds, capital expenditures, tightening up utilization controls, and increasing productivity.

C. Willard Camalier, Jr., M.D., AMA Council on Medical Services, gave a brief description of the history of the medical profession in dealing with three elements: quality, access, and cost. The new emphasis by the AMA on cost control is reflected in the National Commission on Costs of Medical Care. The 1977 report issued by the Commission contains 48 recommendations for cost control. Specific recommendations include: joint efforts by physician groups, hospital people, third-party payers, including insurers and government, to reach agreement on the reasonableness of reimbursement levels for providers of care; experiments by third-party payers to reduce expenditures for inappropriate care; exploration of the idea of paying institutions on the basis of prospectively determined rates; establishment of a formalized voluntary cost containment program supported by the hospital industry, the AMA, and other groups.

* Dr. Blair is the Chairman of the Cost Accountability Committee. His address is 755 Columbia Dr., Decatur, Georgia 30030.

What the Physician Can Do to Cut Costs

Dr. Camalier also recommended what individual physicians could do to assist in cost control: 1) When referring patients to another physician, send old reports, laboratory tests, X-rays, etc. to avoid duplication. 2) Obtain previous reports when such results are needed, again to avoid duplication. 3) Resist patients' pressures and demands to order tests or prescribe treatment and medication that are harmless yet unnecessary. 4) Learn the cost of medications and be aware of competitive brands which may offer a patient the same clinical effectiveness at a lower cost. 5) Determine the policy of your hospital medical staff regarding combination diagnostic tests with routine admission testing, and make sure you have an option to order or cancel these tests individually. 6) Help insure that patients receive care in the most appropriate and effective setting. 7) Order preadmission tests, shorten necessary hospital stays, and notify the hospital when delayed or neglected testing procedures necessitate a longer hospital stay for a patient. 8) Schedule diagnostic tests or procedures on an out-patient basis. 9) When possible, schedule admissions and discharges in order to avoid charges for extra days or weekend stays when needed services may not be available at the hospital. 10) Stress to the patients the proper use of emergency rooms (ER) and tell them to call you first if they're uncertain as to their need for ER services. (In line with this, arrange physician coverage when you are unavailable so patients will not rush to the ER for minor problems.) 11) Finally, encourage your patients to take better care of themselves.

Physicians must resist patients' pressures to order unnecessary tests or medication.

Speaking for the NEA, **Mr. David Foerster** noted that in states where there is no collective bargaining, no health insurance is available to teachers. In states where there are insurance plans, it is becoming increasingly difficult to negotiate as premium costs escalate. The NEA does not endorse national health insurance but does favor legislation for strong cost control.

Mr. Jeffrey L. Goodwin, Associate Director, HIAA, made suggestions regarding the establishment of prospective budget review, certificates of need, an increase in the use of trained medical assistants for routine services, a higher priority for preventive care and public health education, and an improvement in cooperation among the medical profession, the public at large, and the government to try to improve our basically sound health care system.

The immediate concern of business, as expressed by **Mr. Richard Martin,** Manager, Health Services and Industrial Relations, Goodyear Tire and Rubber Company, was the high cost needed to underwrite health care benefits. As an example, Mr. Martin pointed out that his company paid $80 million in 1977 for essentially the same benefits for approximately the same number of people that cost $25 million in 1968. He challenged the group to address such questions as: Should this hospital be operating a maternity unit at 55% occupancy rate? Should this hospital be performing high voltage radiation therapy when the linear accelerator is barely used? Should this hospital have open heart surgery when the one down the street has a unit, but neither hospital does enough to make it medically purposeful or economical?

Benefits that cost Goodyear Tire and Rubber Co. $25 million in 1968 cost $80 million in 1977.

Mr. William E. Ryan, Executive Vice President of Blue Cross/Blue Shield Association, cited efforts of his company in areas of utilization review and establishment of programs to change behavior patterns that accounted for unnecessary costs. They initiated cost education programs for both physicians and subscribers, experimented in different payment mechanisms, and developed a medical necessity program in conjunction with medical specialty organizations.

Representing the Health Care Finance Administration (HCFA), **Mrs. Virginia Smythe** explained that the HCFA was interested in developing a common claims pool and policies that affect reimbursement. It is also investigating all laboratory services and health care delivery systems to limit expenditure and at the same time deal more effectively with the needs of people.

Cost-Increase Culprits

There was a general consensus that the following factors combined to escalate cost of medical care: inflation, government regulations, advanced medical technology, defensive medicine, too many hospital beds, duplication of expensive services, waste and inefficiency (ranging from too many sutures for a surgical procedure to extensive over utilization and over capacity), health insurance and other third-party payment programs which increase demand and mask health care costs. A succinct solution, as seen by the conference, would be to retain control within the private sector, to cooperate, and to educate.

What the various concerned groups can do to cut costs:

Consumer

1. Devise programs to educate the patient regarding his responsibility for his own health. Begin this in the schools.
2. Educate the patient regarding costs masked by insurance coverage.
3. Address consumer expectation issues by education of patient and provider.

Physicians

1. Emphasize cost of treatment to the physicians by providing them with copies of their patients' bills, or listing charges of routine procedures on their order forms.
2. Place more emphasis on cost of medical care in the schools of medicine and internship and resident training programs.
3. Improve admission and discharge planning.
4. Expand utilization review to areas other than length of stay. For example, medical necessity and appropriateness of care.

Hospitals

1. Eliminate excess beds.
2. Coordinate services with other facilities.
3. Establish Cost Accountability Committees and uniform cost accounting.
4. Coordinate efforts with the community in hospital planning.
5. Itemize charges for individual procedures, rather than lumping charges together, e.g., pathology and readiology.

Insurers

1. Standardize the procedural terminology and streamline identification cards and forms.
2. Offer contracts with varying degrees of coverage, giving positive incentives to cost-effective hospitals.

Government

1. Implement standardization of government policy in Medicare and Medicaid.
2. Consider more closely the cost impact of any proposed health regulations or health legislation.

Business

1. Establish prophylactic health measures in communities, particularly with their own employees, such as Stop Smoking Clinics and exercise programs.
2. Involve local physicians, hospitals, and insurers in establishing health care plans.

Medical Leaders Call for Bigger AMA Membership

What is the price of representation of our profession in the ongoing debate on the way medicine is practiced, financed, and administered across our land?

The price of that representation is the $250 membership dues to the American Medical Association (considerably less for physicians in their first year of practice, housestaff, and students). And leaders of many state and county medical societies have been pounding this home.

Noting the cost of the "many AMA activities and services," Guy T. Selander, M.D., wrote last year when president of the Duval County Medical Society, Jacksonville, Florida, "It is the individual doctor's responsibility to carry his/her share of the economic load."

As for complaints that the dues are too high, he said, "Annual dues at most of the Jacksonville area country clubs, all of which have large doctor representation, are higher than membership in the American Medical Association."

Eyeing the Washington scene, George H. Dietz, M.D., wrote in April as president of the Mahoning County Medical Society, Youngstown, Ohio, "Without doubt, the American Medical Association is a potent force in the political arena, working for the good of the patient and the doctor alike. I am amazed at its effectiveness . . . I am convinced that if there were no AMA, some sort of total-care government (federal) program would now long since have been a reality."

In a similar vein, John J. Egan, M.D., president of the Medical Society of Delaware, observes that his society and the AMA "are unifying forces whose role is to blend the viewpoints of all physicians into concerted and effective action. The strength of organized medicine derives entirely from the participation and support of individual physicians."

Likewise calling for unity, John F. Kahle, M.D., immediate past president of the Arizona Medical Association, bemoans those physicians whose response to today's challenges consists of "withdrawing into their own shells, rather than joining or encouraging the fight against the real enemy — governmental intrusion."

These (and numerous other medical society articles we could quote) make it plain that joining the AMA isn't just hopping into a caravan. It's an emergency vehicle that's involved, and the very future of medicine is on the litter.

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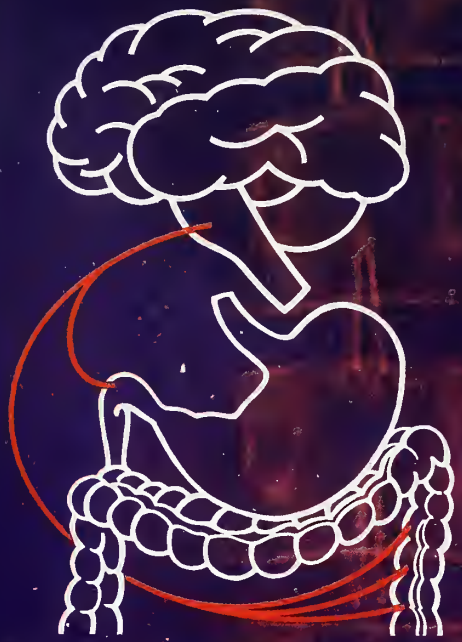
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It is important for the practicing physician to be aware of the symptoms which suggest a more thorough diagnostic work-up.

Clinical Aspects of Bronchogenic Carcinoma

GARY N. HARRISON, M.D., *Augusta**

BRONCHOGENIC CARCINOMA is the leading cause of cancer and death due to cancer in men in the United States today. One approach to this problem is an all-out attack on cigarette smoking, and this attack has been recently undertaken in force by the Department of Health, Education and Welfare. However, cigarette smoking appears to be endemic and difficult to erradicate. Our only hope then, to improve the dismal morbidity and mortality figures associated with bronchogenic carcinoma, is to detect cases earlier so specific therapeutic measures can be undertaken. Ninety-five percent of all patients have been symptomatic a mean of 4 months at the time when they present to their physician. Once bronchogenic carcinoma has been diagnosed, a thorough clinical evaluation is indicated to determine the clinical stage of the tumor and to estimate the ultimate prognosis.

The symptoms of bronchogenic carcinoma depend on the tumor location, the cell type and rapidity of growth of the tumor, any previous pulmonary parenchymal disease, and awareness of the patient. Bronchogenic carcinoma usually presents in one of four symptom-sign complexes: bronchopulmonary manifestations, extrapulmonary intrathoracic manifestations, metastatic manifestations, and paraneoplastic-nonspecific manifestations.

Table 1 shows the common presenting bronchopulmonary symptoms. The most common symptom of bronchogenic carcinoma is a cough, usually of recent onset or increasing insistency. Hemoptysis is a less frequent symptom and is usually modest. Very rarely does the patient cough up frank blood or blood clots. Chest pain due to bronchopulmonary tumor is an ipsilateral, dull, poorly localized pain lasting minutes to hours and is not accentuated by breathing.

TABLE 1
BRONCHOPULMONARY MANIFESTATIONS OF BRONCHOGENIC CARCINOMA

	Per Cent
Cough	73-87
Chest Pain	35-60
Dyspnea	22-58
Hemoptysis	27-57
Wheezing	2
"Sentinel Pneumonia"—Lung Abscess	

Stagnant secretions behind an obstructing or partially obstructing tumor often become infected. A "sentinel pneumonia" is a slowly resolving pneumonia with absent air bronchograms, decreased

* Associate Professor of Medicine, Section of Pulmonary Medicine, Department of Medicine, Medical College of Georgia, Augusta, Ga. 30902.

breath sounds and absence of rales caused by an endobronchial tumor. The presence of a lung abscess in any patient over the age of 50, particularly a smoker, should suggest endobronchial tumor proximal to the abscess or cavitation of a parenchymal tumor mass.

At times the first manifestation of bronchogenic carcinoma will be spread of the tumor outside the lung parenchyma into other structures in the chest cavity (see Table 2). The superior vena cava syndrome, with flushed facies and distended veins of the neck and chest, is most often due to oat cell carcinoma (in 80% of the cases involving the right lung). Hoarseness is due to tumor entrapment of the recurrent laryngeal nerve. The left vocal cord is usually involved. Enlarged subcarinal nodes pressing backward on the esophagus can cause dysphagia.

TABLE 2
EXTRAPULMONARY INTRATHORACIC MANIFESTATIONS OF BRONCHOGENIC CARCINOMA

	Per Cent
Hoarseness	2-18
SVC Syndrome	4-7
Dysphagia	1-5
Arrythmias	
Pancoast Tumor	

The Pancoast syndrome is caused by the spread of a bronchogenic carcinoma (most frequently squamous cell) from the superior sulcus of the lung into the adjacent brachial plexus and ribs. A patient may experience pain in the shoulder radiating down the ulnar side of the arm, due to tumor involvement of the eighth cervical and first thoracic outflow tracts; a Horner's syndrome, due to tumor involvement of the paravertebral sympathetic ganglia; or a variable amount of rib or vertebral body erosion, due to tumor invasion of the bone.

Symptoms of patients initially presenting with metastatic bronchogenic carcinoma are shown in Table 3. Normal lymphatic drainage from the lungs is into mediastinum, thus tumor presents in the supraclavicular, cervical or para-aortic areas. An enlarged axillary or inguinal node is a rare initial manifestation of bronchogenic carcinoma. Bone metastases are usually lytic and occur proximal to the elbow and knee. Intracranial metastases may result in coma, seizures or focal neurological deficits.

TABLE 3
METASTATIC MANIFESTATIONS OF BRONCHOGENIC CARCINOMA

	Per Cent
Lymphadenopathy	22-23
Bone Pain	7-25
Hepatomegaly	21-22
Intracranial	3-13
Skin Lesions	1
Pleural Effusions	

Ninety-five percent of all patients have been symptomatic a mean of 4 months by the time they see their physician.

Pleural effusions may be formed by three mechanisms. Metastatic disease to the lymph nodes of the mediastinum can obstruct lymphatic drainage and result in a nonmalignant exudative effusion. Metastases to the pleural surface result in a hemorrhagic exudative effusion and pleuritic chest pain. Pneumothorax secondary to pleural metastases is an exceedingly rare occurrence. Sterile and septic exudative effusions can be associated with an obstructive pneumonia and/or abscess.

There is a raft of paraneoplastic and nonspecific manifestations of bronchogenic carcinoma which can be exceedingly confusing to the practicing clinician. As Table 4 shows, weight loss is a common symptom but nonspecific. Clubbing of the digits is the most common physical finding in bronchogenic carcinoma. Pulmonary hypertrophic osteoarthropathy, painful periosteal and synovial inflammatory change at the ends of long bones and joints, is seen in 10% of cases, usually with adenocarcinoma.

TABLE 4
NONSPECIFIC MANIFESTATIONS OF BRONCHOGENIC CARCINOMA

	Per Cent
Weight loss	8-69
Clubbing	12-21
Hypertrophic Osteoarthropathy	4-12

However, hypertrophic osteoarthropathy can be seen with a number of other benign and malignant diseases of the lung, especially mesothelioma and sarcoma metastatic to the lungs.

Table 5 lists nonspecific vascular and hematologic abnormalities in bronchogenic carcinoma. Bronchogenic carcinoma is the most common cause of migratory thrombophlebitis in men. The thrombophlebitis may precede other symptoms of bronchogenic carcinoma by more than a month. Cryofibrinogenemia rarely occurs, but, interestingly is generated by activation of the blood clotting cascade, not due to the production of an abnormal M component.

TABLE 5
HEMATOLOGIC PARANEOPLASTIC MANIFESTATIONS

Hemolytic Anemia
Thrombotic Thrombocytopenic Purpura
Migratory Thrombophlebitis
Marantic Endocarditis
Cryofibrinogenemia

Table 6 shows the nonspecific dermatological manifestations of bronchogenic carcinoma. Increased risk of lung cancer in patients with interstitial lung disease due to scleroderma is well known, as is the association between dermatomyositis and cancer. The sign of Leser-Trelat, the sudden appearance of seborrheic keratoses on the trunk, can be seen in a variety of malignancies.

TABLE 6
DERMATOLOGIC PARANEOPLASTIC MANIFESTATIONS

Acanthosis Nigricans
Dermatomyositis
Tylosis
Scleroderma
Sign of Leser-Trelat

The most common hormonal abnormality in bronchogenic carcinoma is hypercalcemia. It is seen most commonly with squamous cell carcinoma, less frequently with large cell adenocarcinoma, and very rarely with oat cell carcinoma. Hypercalcemia associated with a low serum phosphorus level suggests that the tumor is secreting parathyroid hormone (PTH) or PTH-like substances. A normal serum phosphorus in the presence of hypercalcemia suggests either prostaglandin secretion or osteolytic metastatic lesions.

Bronchogenic carcinomas can synthesize an amazing variety of hormones and hormone-like substances (Table 7). The syndrome of inappropriate antidiuretic hormone secretion, the second most common hormonal abnormality after hypercalcemia, is frequently associated with oat cell carcinoma or carcinoid tumor. The release of the adrenal corticotrophic and/or beta melanocyte stimulating hormone may result in a Cushing's syndrome, with or without hyperpigmentation. Release of human choriogonadotrophin and/or luteinizing hormone is rare, but has been associated with gynecomastia and breast tenderness in men. Release of insulin, particularly by squamous cell tumors, has been associated with profound and recalcitrant hypoglycemia. Release of calcitonin and other hormones have been documented but cause no overt clinical syndromes.

TABLE 7
HORMONES SECRETED BY BRONCHOGENIC CARCINOMA

ADH
ACTH/B-MSH
HCG/LG
PTH
Calcitonin
Insulin

Lung cancer is the most common type of cancer to have neurological paraneoplastic manifestations. Table 8 shows the spectrum of neurological disease. In 50% to 85% of cases, neurological symptoms precede tumor detection by four years to six months. Thirty-five percent of all patients with paraneoplastic neurological disease secondary to bronchogenic carcinoma have a negative chest x-ray when first seen. The neurological deficit appears suddenly, evolves over days to weeks, and then stabilizes. Lesions of the central nervous system rarely improve with control of the tumor or with steroid administration. The Eaton-Lambert Syndrome, the so-called "reverse myasthenia" seen with oat cell carcinoma, causes a profound proximal muscle weakness. In contrast to mysathenia gravia, the weakness transiently improves with repeated muscle retractions, ocular or bulbar involvement is uncommon, tendon reflexes are decreased or absent, there is a poor response to neostigmine, and a good response to calcium or guanidine.

"The most common hormonal abnormality in bronchogenic carcinoma is hypercalcemia."

TABLE 8
NEUROLOGICAL PARANEOPLASTIC MANIFESTATIONS

CNS Disease
Encephalopathy
Corticocerebellar degeneration
Spinocerebellar degeneration
Cord Disease
Myelopathies
Subacute Carcinomatous Poliomyelitis
Peripheral Neuropathy
Sensory
Mixed Sensorimotor
Myopathy
Polymyositis
Eaton-Lambert Syndrome

Once the diagnosis of bronchogenic carcinoma has been established, the extent of the tumor is defined by clinical signs and symptoms, lymph node or liver biopsy specimens, and various endoscopic examinations, is recorded. This "clinical-diagnostic staging" procedure may obviate the need for surgical staging by thoracotomy.

Evaluation of the "performance status" (PS) of patients with bronchogenic carcinoma using, for example, the Karnofsky Scale, will allow one to

make a prognostic estimate of the median life expectancy of the patient. For example, the unresectable, untreated lung cancer patient who lives at home but can't work or carry on normal activities (PS = 70%) has a median survival of 10+ weeks. Whereas the patient who requires hospitalization or equivalent care will not likely live longer than 4 weeks.

There are no sure cures for most persons with lung cancer, only rational alternatives. Familiarity with the bronchopulmonary, extrapulmonary intrathoracic, metastatic and paraneoplastic manifestations of bronchogenic carcinoma is essential for the practicing clinician to make reasonable and compassionate decisions concerning diagnostic evaluation and therapy of his patients.

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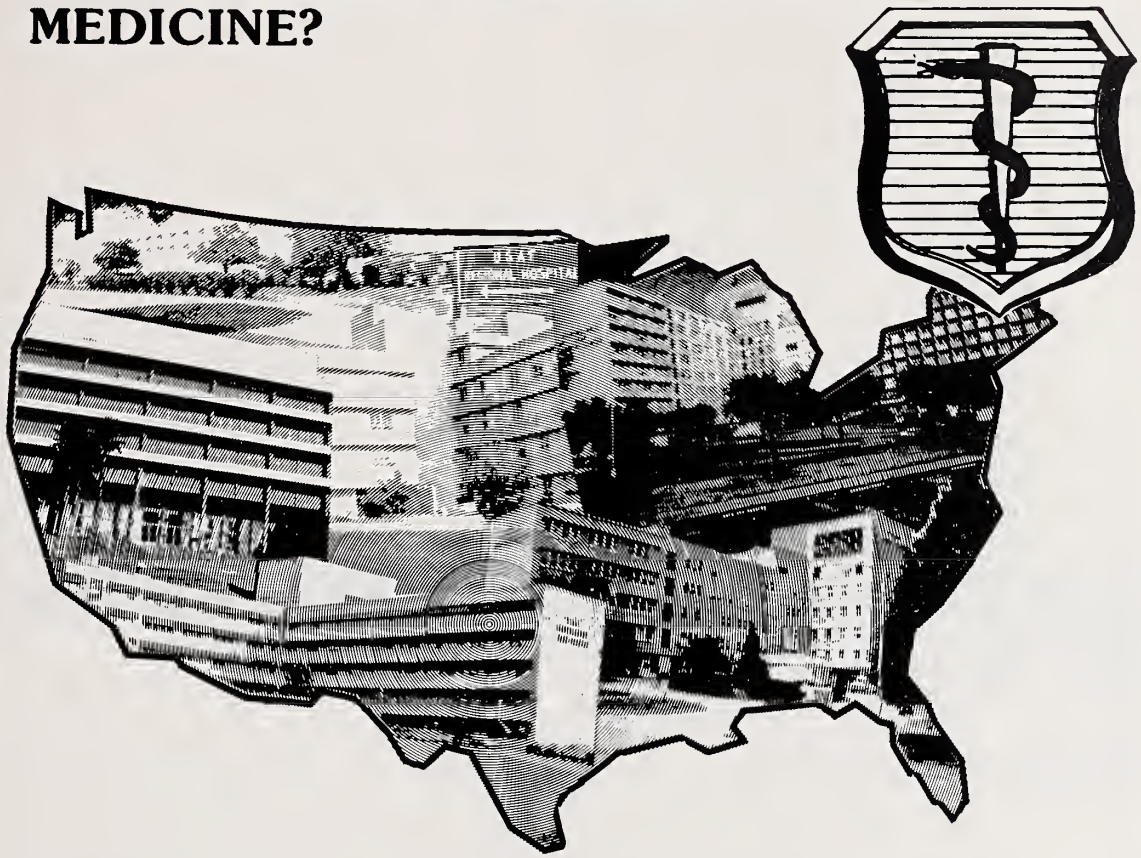
Emory to Establish Genetics Center for Middle Georgia in Macon

Emory has received a grant of $4,520 from the National Foundation March of Dimes, Middle Georgia Chapter, to establish a genetics program in the Medical Center of Central Georgia in Macon. This is the second of eight such centers that are planned to provide Georgia with a comprehensive genetics program. The first one was established in Dalton.

Dr. Louis J. Elsas, II, Director of the Division of Medical Genetics, Department of Pediatrics, Emory School of Medicine, said, "The most important functions of a comprehensive genetic program are to provide both laboratory and clinical diagnostic services to detect heritable diseases. Given an appropriate diagnosis, the science of genetics can then predict and thereby prevent irreversible disease manifestation."

Another function of a genetics program is to provide trained physicians, nurses, and other professionals who can offer genetic diagnosis and counseling to parents who may be at high risk for having children with birth defects. Other functions include developing a rapid retrieval system for newborns who are at high risk for having one of six inherited metabolic diseases (phenylketonuria, maple syrup urine disease, hypothyroidism, galactosemia, tyrosinemia, or homocystinuria) causing mental retardation.

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Epidural Dorsal Column Stimulation for Relief of Intractable Pain

GARY E. KAUFMANN, M.D., *Marietta**

NEUROSURGEONS ARE USING epidural dorsal column stimulation with increasing frequency to relieve intractable pain usually associated with low-back problems, terminal cancer, postamputation syndrome, and causalgia. Approximately 10 years ago, Norman Shealy implanted the first dorsal column stimulator using the open laminectomy technique.[1] This procedure has since been performed on over 3,000 patients; however, less than 50% have experienced any long-term pain relief.[2] In view of these results and of the need for major surgery to implant and/or remove the electrodes, the popularity of this procedure declined. The more recent development of percutaneous insertion of electrodes into the spinal epidural space for stimulation has virtually replaced the laminectomy procedure. Long and his associates have used this more recently developed procedure and report favorable results.[3]

* Dr. Kaufmann's address is Urban Medical Doctors Building, 2550 Windy Hill Rd., SE, Marietta, Georgia 30069.

Case Report

A 50-year-old white male underwent a lumbar laminectomy for disc disease in 1966. His low-back pain persisted, however, and he underwent a lumbar fusion later in the year. He experienced moderate pain relief until 1971, when he fell and reinjured his back. A myelogram in 1972 revealed a complete block secondary to severe arachnoiditis. A lumbar laminectomy at L3 provided no relief of back and left leg pain. Similarly, a lumbar sympathectomy with alcohol and an L4-5 rhizotomy performed in 1972 failed to alleviate the patient's pain.

In May 1973, the patient had a dorsal column stimulator implanted using the laminectomy procedure, and he experienced almost complete (80%) relief of his pain. He returned to work in late 1973. From 1974 through 1977, the stimulator continued to relieve his back pain; however, the pain in his left leg gradually returned. Multiple procedures were tried unsuccessfully to relieve the pain. Then in 1977, an epidural dorsal column stimulator was implanted, and the residual pain in his leg diminished appreciably. He no longer uses his wheel chair, has cut back greatly on his drug intake, and has resumed many of his routine activities.

Technique

The patient is placed on the operating table in the prone position and locally anesthetized. Touhy-type epidural needles are inserted percutaneously into the spinal epidural space in the upper lumbar region. Flexible platinum electrodes are then threaded through the needles into the epidural space while electrical stimulation is effected via a radio frequency generator. When the patient reports feeling stimulation in the affected area and relief from his pain, the skin is incised and the electrodes are secured to the lumbodorsal fascia. The proximal end of the electrodes are tunneled subcutaneously and connected to the receiver which is implanted on the right lower chest anteriorally. Stimulation is then applied from the patient's transmitter through the antenna and the patient's own receiver to the electrode.

The operation usually lasts from 1½ to 2 hours. Since local anesthesia is used, even the most debilitated or otherwise high-risk patients can safely undergo this procedure. It costs slightly more than a laminectomy and is paid by almost all major insurance carriers. The patient is usually hospitalized for 5 days.

I implanted 32 of these systems between 1977 and 1978. Twenty-six patients (81.2%) are experiencing good pain relief. Six patients have had their stimulators removed: two because of infection, three because they could not tolerate the sensation, and one because of an allergic reaction. Two patients failed to get adequate stimulation in the operating room, and the procedure was discontinued. There were 21 revisions of electrodes in 13 patients, for a revision rate of 40%. The slippage of the electrodes is the most common problem faced. A new electrode configuration has been used recently in more than 30 cases, and no revisions have been necessary.

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Fourth Annual Holiday Infectious Diseases Seminar-Update 1978

The Georgia Baptist Medical Center's (GBMC) Fourth Annual Holiday Infectious Diseases Seminar will be held on Friday, December 8, 1978, at the auditorium in the Nursing Education Building from 8:30 a.m. to 5:30 p.m.

The objectives of the seminar are: to provide physicians and their health care team up-to-date information on the prevention, diagnosis, and care of infected patients; to inform the health care team about resources in infection control; to reemphasize the therapeutic advantages and complications of antimicrobial agents; to hear recent developments from the Center for Disease Control (CDC); to promote understanding of microbial pathophysiology and antimicrobial pharmacokinetics; and to discuss the prophylaxis and treatment of infections in office practices.

Physicians and house staff from any hospital are cordially invited to attend, and nursing and other allied health personnel are also welcome.

Featured speakers in the morning session will be: William H. Foege, M.D., Director of CDC, "CDC Overview — Services and Programs for the Physician and Patient Care"; Claire V. Broome, M.D., from CDC, "The New Faces of Legionnaire's Disease"; Richard E. Dixon, M.D., from CDC, "Nosocomial Infections — The Patient, the Physician, and Cost Containment"; Richard E. DuBois, M.D., from GBMC, "An Innovative Infectious Disease Unit for Improved Isolation and Treatment of Difficult Problems"; A. David Brandling-Bennett, M.D., from CDC, "Current Recommendations for Adult and Childhood Immunizations"; John G. Leonardy, M.D., from GBMC, "Immunology of Infectious Diseases"; Jonas A. Shulman, M.D., from Emory, "Newer Infectious Disease Problems Confronting the Internist — Clinical Management"; Andre J. Nahmias, M.D., from Emory, "New Problems of Infections in Pediatrics — Clinical Management."

John P. Wilson, M.D., from Emory, will introduce the keynote speaker, Ronald L. Nichols, M.D., M.S., from Tulane, who will address the subject of "Sepsis in the Surgical Patient — Diagnosis and Treatment."

In the afternoon session, the featured speakers will again be Dr. Ronald L. Nichols, "Prophylactic Antibiotic and Other Preventive Management of Infections in Surgery (including Nosocomial, Vascular, and Cardiac)"; Dr. Jonas Shulman, "Update — Antimicrobial Treatment of the Seriously-Ill Hospital Patient"; Dr. Andre J. Nahmias, "Update — Recognition and Management of Viral Infections and Viral Latency"; and Dr. Richard E. DuBois, "Update — Antimicrobial Therapy of Non-hospitalized Patients." Dr. Nichols will give the closing comments, with a wrap up by James S. Maughon, M.D.

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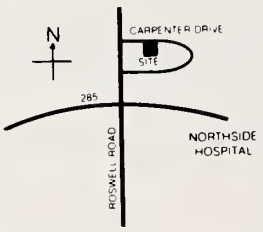
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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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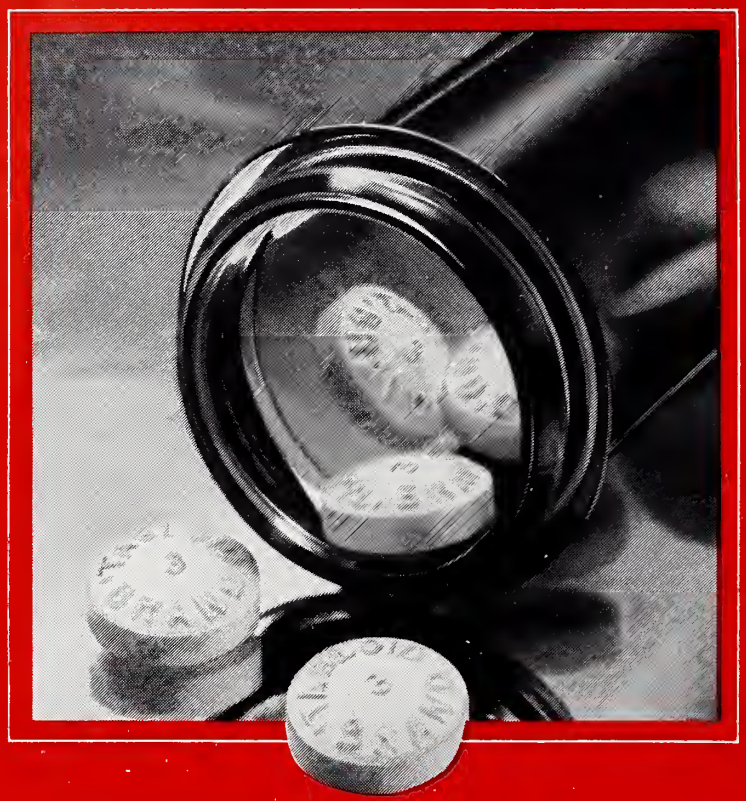
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A Vascular Lesion of the Brain

ROBERT PRICE, M.D., LAMAR TEAFORD, M.D., and AYTEN SOMEREN, M.D., *Atlanta**

Dr. ROBERT PRICE: The patient is an 18-year-old male with a history of seizure disorder, who had been on Dilantin therapy for one year. The patient was admitted to the hospital with a history of headache associated with nausea and vomiting and a grand mal seizure. The physical examination revealed left hemiparesis and a positive left Babinski sign. A CAT (computed axial tomography) head scan was obtained on admission (Fig. 1). Dr. Teaford, will you interpret the results?

Dr. Lamar Teaford: With the patient in supine position, serial scans of 1 cm thickness were obtained through the skull. There was demonstrated on a noncontrast scan a 4 x 6 cm high density lesion with an absorption coefficient of blood in the right parieto-occipital area. Blood was also noted in both lateral ventricles as well as the 4th ventricle. No skull fracture, abnormal calcifications, or evidence of subdural hematoma were identified. These findings are consistent with an intracerebral hemorrhage into the right parieto-occipital area with secondary hemorrhage into the ventricular system.

The diagnostic considerations would include an arterio-venous malformation (AVM), intracerebral hemorrhage secondary to systemic arterial hypertension, trauma, or anticoagulants, ruptured aneurysm, and malignant neoplasm. The most likely diagnostic possibilities are AVM, neoplasm and aneurysm. Angiography would be the procedure of choice in the differential diagnosis of these possibilities.

Dr. Price: Angiography was performed the second day of admission (Fig. 2). Would you comment on this examination?

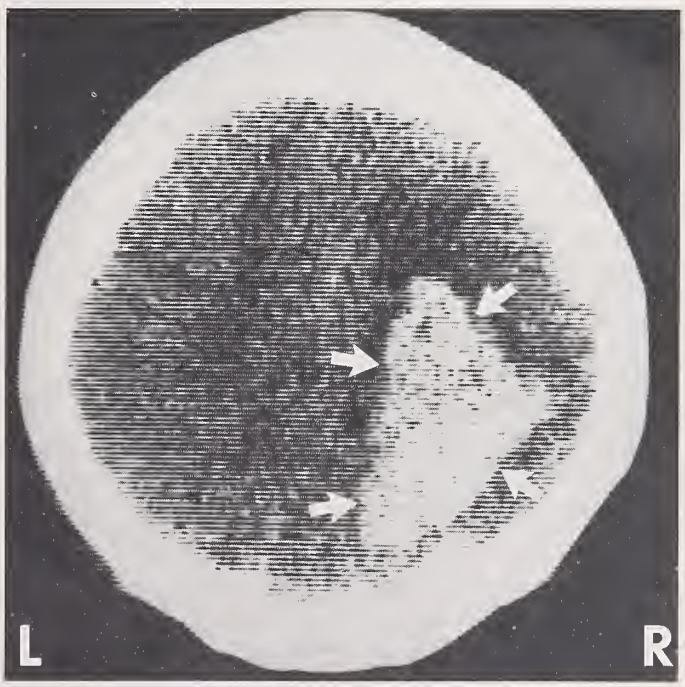


Figure 2 — AP view of arterial phase of right internal carotid angiogram. Arrows indicate the AVM adjacent to interhemispheric fissure of right parieto-occipital area, supplied by branches of right middle and anterior cerebral arteries.

* Emory University School of Medicine, 80 Butler St., SE, Atlanta, Ga. 30303. Drs. Price and Teaford are from the Department of Radiology and Dr. Someren is from the Pathology Department. The conference material has been edited by Drs. J. L. Clements and H. S. Weens.

Dr. Teaford: The right internal carotid injection demonstrated tortuous enlarged anterior and middle cerebral arteries supplying a large AVM in the right parieto-occipital area, which abuts the interhemispheric fissure. The greater arterial supply was by way of the anterior cerebral artery. There was minimal mass effect in the region of the AVM as well as mild hydrocephalus as evidenced by the course of the pericallosal artery. The left internal carotid artery injection demonstrated a tortuous anterior cerebral artery whose branches also filled the AVM, but to a lesser extent than the right.

Dr. Price: The patient then underwent craniotomy and the hematoma was evacuated and the AVM ligated and excised. Dr. Someren, would you comment on the histology of the lesion?

Dr. Someren: The gross specimen consisted of a portion of cerebral cortex and overlying meninges measuring 8 x 5.5 x 2.5 cm. On the meningeal surface, there was noted an abnormal collection of enlarged tortuous blood vessels. On section, the brain showed areas of fresh hemorrhage together with clusters of blood-filled cystic spaces representing abnormal vessels within the parenchyma. The microscopic appearance was that of a typical AVM with presence within the leptomeninges of an aggregate of large tortuous blood vessels, many with excessively thickened walls. In some areas, they form a cavernous-type network interspersed by islands of brain tissue. These vessels are both arteries and veins and many are structurely hybrids.

AV malformations may be seen anywhere in the brain but are most common above the tentorium and mostly on the lateral hemispheric surfaces. The most attractive explanation for the genesis of AVM is the focal congenital absence of a capillary bed. This theory is in agreement with the arteriographic finding of arteriovenous shunting and it is also supported by observation of noncapillary communications between arterial and venous circulations in microscopic sections. Enlargement and muscular hypertrophy of the veins are the result of the shunting.

Discussion

Arterio-venous malformations are the most common of all intracranial vascular malformations and may occur anywhere within the central nervous system. Most intracranial AVM's are supratentorial and pial in location. They derive their blood supply solely from the internal carotid and vertebral artery circulation. They present most commonly with subarachnoid hemorrhage and have been said to account for 10% of all subarachnoid hemorrhages. Occasionally, AVM's may be associated with intracerebral hemorrhage and rarely produce hemorrhage into the subdural and intraventricular spaces.

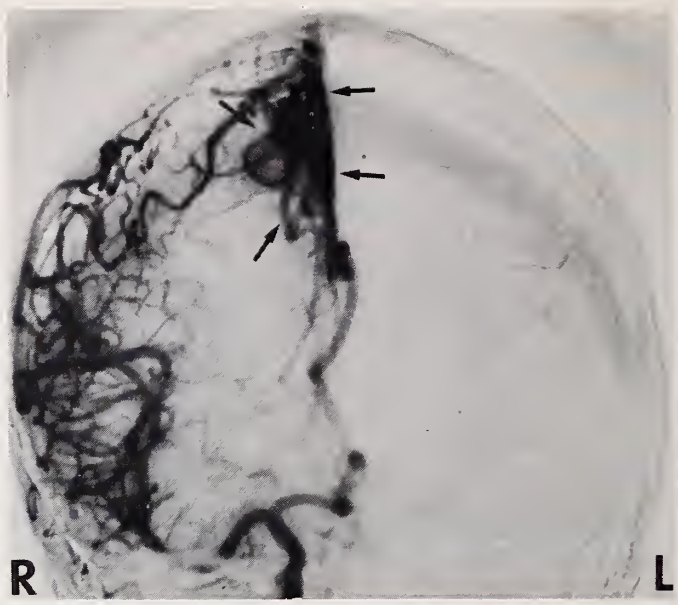


Figure 1 — Upper section from patient's non-contrast CAT head scan. Arrows indicate 4 × 6 cm. high density lesion with an absorption coefficient of blood in right parieto-occipital area, consistent with intracerebral hemorrhage.

The CAT brain scan in nonhemorrhagic AVM may either appear normal or as a low density or slightly above brain density irregular to ill-defined area. The CAT brain scan with intravenous contrast causes dramatic enhancement in demonstration of the few to many localized curvilinear tubular structures to an irregular mass density.

The CAT brain scan results of the current case demonstrate clearly the important impact this remarkable diagnostic tool has made in medicine, specifically neuroradiology, neurology and neurosurgery. The rapid, detailed and exact information yielded by the CAT scan has indeed revolutionized the diagnostic approach and evaluation of the brain and its disorders. CT scanning clearly demonstrates recent hemorrhage and is considered to be superior to other diagnostic modalities in the diagnosis of intracerebral hemorrhage. A normal CT scan may obviate the need for further radiographic investigation. Furthermore, its utilization may enable the diagnostic evaluation of a patient to forego other more invasive and potentially hazardous procedures.

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The enviable experience here reported could well be a prototype for similar programs in other communities throughout the state.

Health Education Seminars in Columbus Are a Success

BARBARA RIVERS* and TOM TITUS†

PUBLIC RESPONSE to a series of community education programs held at The Medical Center in Columbus, Georgia, has been overwhelming, with the public welcoming the chance to see and hear physicians discuss health education topics in a setting other than the traditional one-to-one physician-patient relationship.

Community education is an important objective of The Medical Center, and for that reason, hospital officials decided to model this series after the successful seminars recently held in Atlanta and sponsored by the Medical Association of Atlanta. The hospital secured the approval of the Muscogee County Medical Society and obtained the cooperation of the Columbus Ledger and Enquirer newspapers which co-sponsored the event with The Medical Center. The seminars were held in The Medical Center auditorium, and each of the three programs held thus far has drawn standing-room-only attendance.

At each session, the panelists made short opening remarks, with most of the program devoted to questions and answers. The first topic, "T.N.T.," dealt with the "explosive" issue of tension, nerves, and tranquilizers. An estimated 335 people attended. C. Daniel Cabaniss, M.D., Director of Medical Education at the hospital, served as moderator of a panel composed of Richard N. Robertson, Director of the Columbus Pastoral Institute; Hugo J. Zee, M.D., Director of Therapy at the Bradley Center; Bob R. Maughon, M.D., psychiatrist with the Smith Clinic; and Norman I. Goldman, M.D., internist.

The August seminar entitled ". . . To Save Your Life" dealt with exercise, weight control, and other risk factors. Because of the large response, some people were turned away at the door, so the seminar was repeated and again produced standing-room-only attendance. An estimated 700 people attended the two programs. Dr. Cabaniss was the moderator, and panel members included Columbus internists Garry August, M.D., Gordon C. Miller, M.D., and Thomas A. Wade, Jr., M.D.

For their part in the sponsorship, the local newspapers provided several full-page and quarter-page advertisements announcing the seminars several days ahead of the program. They also ran feature articles based on interviews with program participants to give a more detailed explanation of what the public could expect from the panel. Newspaper staff also designed and printed posters and brochures for each seminar.

The Medical Education and Community Relations Department of The Medical Center coordinated and planned the seminars at every stage. They contacted and made all speaking arrangements, set up the facilities, coordinated publicity by distributing the brochures and posters to local businesses and physician offices, and arranged for news coverage of each program.

Hospital and newspaper officials plan to continue the seminars on a quarterly basis as long as public interest is maintained. The next session is tentatively scheduled for the end of November. It will be repeated on two or more nights to allow more people to attend. Audience suggestions for future topics are being considered by the seminar planning committee. Future topics will include programs on selected aspects of parenting, human sexuality, pain, and recent developments in the prevention, early detection, and treatment of cancer.

* Barbara Rivers is Community Relations Specialist at the Medical Center in Columbus, P.O. Box 951, Columbus, Ga. 31912.

† Tom Titus is the Director of Community Relations at the Medical Center.

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An attempt has been made to point out ways in which improvement in the perinatal outcome in Georgia may be affected.

The Use and Misuse of Neonatal Transport Service

WILLIAM P. KANTO, JR., M.D., *Atlanta, and*
ALEX F. ROBERTSON, III, M.D., *Augusta**

Introduction

REGIONALIZATION of neonatal care is effective in reducing newborn morbidity and mortality.[1] Essential components of this system are a regional neonatal intensive care unit which provides tertiary level care for all infants born within a given geographic area and an organized transport service to move the newborn from the hospital of birth to the regional center.[2-4]

The success of neonatal regional programs may be a two-edged sword. Despite the increasing evidence that a safer and more effective form of transport is antenatal or maternal transport,[5, 6] and despite the expressed concerns about the hazards of neonatal transport,[7] the advantages of neonatal referral may be encouraging physicians to deliver neonates in primary or secondary hospitals and then transfer them if they don't do well. This may result in an infant being delivered in an environment inadequate for his requirements for extrauterine support.

We have reviewed one year's (1975) experience with a neonatal transport team to determine the type of procedures required during transport in order to be sure that our staff was adequately trained and equipped, and also to assess the requirements of transfered infants during the process of being moved from the hospital of delivery to the regional center. In 1975, there were very few maternal transfers, and the prevailing practice within the region was to deliver a high-risk infant in the community hospital and then to arrange transfer if adequate care could not be provided for the infant at his hospital of birth.

Methods

The transport log and hospital record of all neonates transported by the Medical College of Georgia Transport Team (MCGTT) for the calendar year 1975 were reviewed. The transport log is maintained by the transport nurse during transport and is a record of: 1) the assessment of the neonate when care is assumed by the MCGTT; 2) procedures performed by MCGTT during stabilization of the infant and/or while in transit; and 3) the course of the patient once care is assumed by the MCGTT. Information collected included birth weight, gestational age, admitting diagnosis, procedures performed during stabilization and transport of the infant, age of the infant when care was assumed by the MCGTT, and outcome.

. . . transport personnel must be capable of providing life support during the transfer process. . .

* Dr. Kanto is the Associate Professor of Pediatrics at the Emory School of Medicine. His address is Department of Pediatrics, Division of Neonatal-Perinatal Medicine, Emory University School of Medicine, Atlanta, Georgia 30303. Dr. Robertson is the Professor and Chairman of the Department of Pediatrics at the Medical College of Georgia. His address is Medical College of Georgia, Augusta, Georgia 30902.

The MCGTT provides transport for sick neonates from their hospital to the regional Neonatal Intensive Care Unit (NICU) at Eugene Talmadge Memorial Hospital (ETMH). In 1975, 198 neonates were transported from 27 community hospitals, with an approximate 10-12,000 deliveries per year. The community hospitals were within 100 miles of ETMH. Movement was by ambulance, and the average time required to assemble the transport team was ½-1 hour. The time required to travel from the regional center to the community hospital ranged from 30 minutes to 3 hours.

The transport team consisted of two persons selected from three professional categories: 1) a physician, either a pediatric house officer or neonatologist, 2) a transport nurse (an intensive care nurse with 4 months of supplemental training in stabilization of the neonate and performance of procedures), or 3) a neonatal intensive care unit staff nurse. The composition of the team was determined by telephone assessment of the infant's status at the time of the request for transfer and the availability of personnel.

Results

Of the 198 neonates transported by the MCGTT in 1975, a total of 137 (69%) survived. During this period, 93 of 130 (72%) of inborn admissions to the NICU survived. Table 1 contrasts survival with birth weights and gestational age of the transported admissions to the NICU. Survival rates generally improved with increasing birth weight and gestational age, as has been previously reported.[8] Of interest is the survival rate of 52% in transported infants of 1000 grams or less birth weight, reflecting the improved survival for these infants in comparison with previous reports.[9]

TABLE 1
SURVIVAL OF TRANSPORTED INFANTS, BY BIRTH WEIGHT AND GESTATIONAL AGE

	Transported Admissions			
	Number	Transports %	Survived	Survival %
Birth Weight (gms)				
<1001	33	17	17	52
1001-1500	36	18	23	64
1501-2000	29	15	17	59
2001-2500	30	15	26	87
>2500	70	35	54	77
Total	198		137	69
Gestational Age (weeks)				
<31	36	18	15	42
31-32	24	12	17	71
33-34	30	15	19	63
35-36	31	16	23	74
>36	77	39	63	82
Total	198		137	69

A total of 127 (65%) of the 198 transported infants had an admitting diagnosis of some form of respiratory distress (Table 2). Of these 127 infants, 84 (66%) had Respiratory Distress Syndrome (RDS), and 43 (34%) had other diseases which presented as respiratory distress. The importance of respiratory disease in the newborn is further reflected in the procedures performed by the MCGTT. Of the 127 infants with respiratory distress, 54 (43%) required some form of ventilatory support, i.e., endotracheal intubation (54), mechanical ventilation (44) or continuous positive airway pressure (CPAP) (10). This represented 27% (54) of the total number of infants transported. Umbilical vessel catheterization was performed in 48 (24%) of transported infants, while intravenous catheters were inserted and used in 50 (25%) of the patients. Some patients already had intravenous or umbilical vessel catheters in place and were not counted in our data collection system since we were analyzing only the procedures performed by the MCGTT.

The care of 109 (45%) of the transported infants was assumed by the MCGTT within the first 12 hours of life (Table 3). By 24 hours of age, 138 (73%) of the infants had been reached and their care assumed by the MCGTT.

Discussion

Our experience clearly shows that the transport of critically-ill neonates is a procedure more complicated than the mere physical movement of an infant from the hospital of birth to a regional center. An essential component of this technique, if it is to be successful in reducing neonatal morbidity and mortality, is the proper stabilization of the infant prior to transfer. Stabilization includes: 1) provision of a neutral thermal environment, 2) securing an adequate airway, 3) prevention or treatment of hypoxia, 4) correction of acid-base abnormalities, 5) maintenance of adequate circulating blood volume, 6) treatment and prevention of hypoglycemia, and 7) institution of antibiotic therapy, if indicated.

When difficulty with the infant or the mother is anticipated, the mother should be moved to a hospital providing tertiary level care before delivery.

Once stabilization is accomplished, the transfer of the infant must be performed so as to: 1) prevent undue stress to the infant, 2) continue to provide the environment required during stabilization, and 3)

TABLE 2
ADMITTING DIAGNOSIS OF TRANSPORTED PATIENTS AND PROCEDURES PERFORMED BY MCGTT DURING STABILIZATION AND TRANSPORT

Diagnosis	Total	Survived	Procedure	Number	Transports %
Respiratory distress syndrome	84	49	Endotracheal intubation	54	27
Respiratory distress*	43	36	Mechanical vent. and/or CPAP	54	27
Premature	37	30	Peripheral infusion	50	25
Congenital heart disease	13	8	Umbilical vessel catheterization	48	24
Birth asphyxia	13	7	Intravenous glucose for hypoglycemia	39	20
Other†	8	7	Intravenous calcium	7	4
Total	198	137	Blood transfusion	6	3

* Includes meconium aspiration, intrauterine pneumonia, transient tachypnea of the newborn.
† Includes hyperbilirubinemia, multiple congenital anomalies, seizures.

institute additional therapy during transfer if the infant's condition so requires. These requirements necessitate that transport personnel must be capable of providing life support during the transfer process including endotracheal intubation, ventilation using either a self-inflating bag or mechanical ventilator, establishment of intravascular lines, and continued assessment of the infant both clinically and biochemically during the transfer.

TABLE 3
AGE OF TRANSPORTED PATIENTS WHEN CARE IS ASSUMED BY THE MCGTT

Age (hours)	Number (Total = 198)	Transports %	Cumulative %
<6	66	33	—
6-12	43	22	55
13-24	29	15	70
25-48	24	12	77
49-72	12	7	94
>72	24	12	100

The equipment necessary to accomplish these goals must be readily available to the transport team during both stabilization and transfer. Listed in Table 4 are the items which we feel are essential for a safe transport. We would also include within the required equipment a stable mode of movement, preferably with a method for communication between the vehicle and the center during transfer.

These requirements do not dictate that only tertiary centers should perform the transport of ill newborns. Transports to the tertiary center originating in the community hospital have been employed in Alabama without increase in neonatal morbidity and mortality.[10] However, they do necessitate that transport be an organized procedure, planned in advance, and not performed on a sporadic basis in response to an emergency. Prior planning and preparation are the sine qua non of a successful infant transport.

Our data indicate that provision of life-support techniques, such as mechanical ventilation and/or continuous distending pressure, were required by a large number of infants (54 or 27%) prior to arrival in the NICU. This is not surprising, since the major diagnosis which necessitated transport was some form of respiratory distress (127 patients or 64%). Of these patients, 84 (66%) had RDS, a disease confined to the prematurely-delivered infant. Our experience indicated that the provision of ventilatory support by the transport team was instrumental in the survival of a number of the transported infants. Further, since in the vast majority of instances where ventilatory support was required, it was initiated at the referring hospital; it was the infant's disease that necessitated intervention and not a clinical deterioration which resulted from the stress of the infant being transferred.

The transport of critically ill neonates is more complicated than the mere physical movement from one hospital to another.

Studies have shown reduced morbidity in infants with RDS when techniques such as CPAP are applied early in the infant's course.[11, 12] The availability of these therapeutic modalities early in the infant's course is one of the major reasons for the improved survival of premature infants delivered in hospitals with NICU.[1] Certainly, those infants who are at great risk for the development of RDS should be delivered in hospitals capable of caring for this

particular problem. The use of techniques for assessing fetal lung maturity and the appreciation that 60% of infants born at 32 weeks gestation or less will experience RDS should allow the physician to accurately predict the infant at risk and arrange for this infant to be delivered in a hospital capable of providing the predicted care required by the infant.[13] This was studied by Merenstein *et al.* who showed that when the mother was transferred and the infant delivered at the regional center, the neonatal survival rate was greater than expected, but if the infant was delivered in the community hospital, and then transferred to the regional center, the survival rate was less than expected.[5] This, of course, does not imply that all mothers should have their babies in a regional center. When difficulty with the infant and/or mother is anticipated, however, the care required should be evaluated, and if that particular hospital is unable to provide it, the mother should be transferred to an appropriate hospital. Since the care may be required either by the mother or the infant, there must be a joint determination of the care capability of that particular hospital by the obstetric and pediatric members of the hospital staff. Once this capability is defined, the patients (mother and/or infant) whose care requirement can be expected to fall outside this capability can then be identified, and the alternative method of caring for these patients initiated. If special care for the mother and/or infant is not required once the infant is delivered, both mother and baby can be returned to the original hospital for the remainder of the hospitalization.

A program of maternal transfer for delivery has been developed in Arizona[6] and can be operated locally in Georgia. Development of a statewide program for Georgia should be a major goal in health planning if maternal and neonatal morbidity and mortality are to be minimized.

Even with a statewide program of maternal transfer, there will still be a need for neonatal transport services. A significant number of low-risk mothers will convert to a high-risk status during labor and delivery.[14] Since it will be impossible to transfer many of these mothers, every hospital delivering babies must be capable of stabilization procedures as were described above. To wait until a transport team arrives for stabilization is unacceptable and may result in significant neonatal morbidity and mortality. Stabilization must be performed immediately, and this responsibility rests with the hospital and attending physician. Once stabilization has been accomplished, an organized transport service can move the infant within a safe environment to a hospital capable of providing the necessary continuing care.

TABLE 4
EQUIPMENT REQUIRED FOR TRANSPORT OF ILL INFANTS

Transport incubator
Oxygen source
Oxygen blender and humidifier
Blood pressure monitoring equipment
Temperature probe and monitor
Intravenous fluids
Infusion pump
Cardiac monitor
Method of mechanical ventilation
Resuscitation equipment including drugs
Alternate electrical power source

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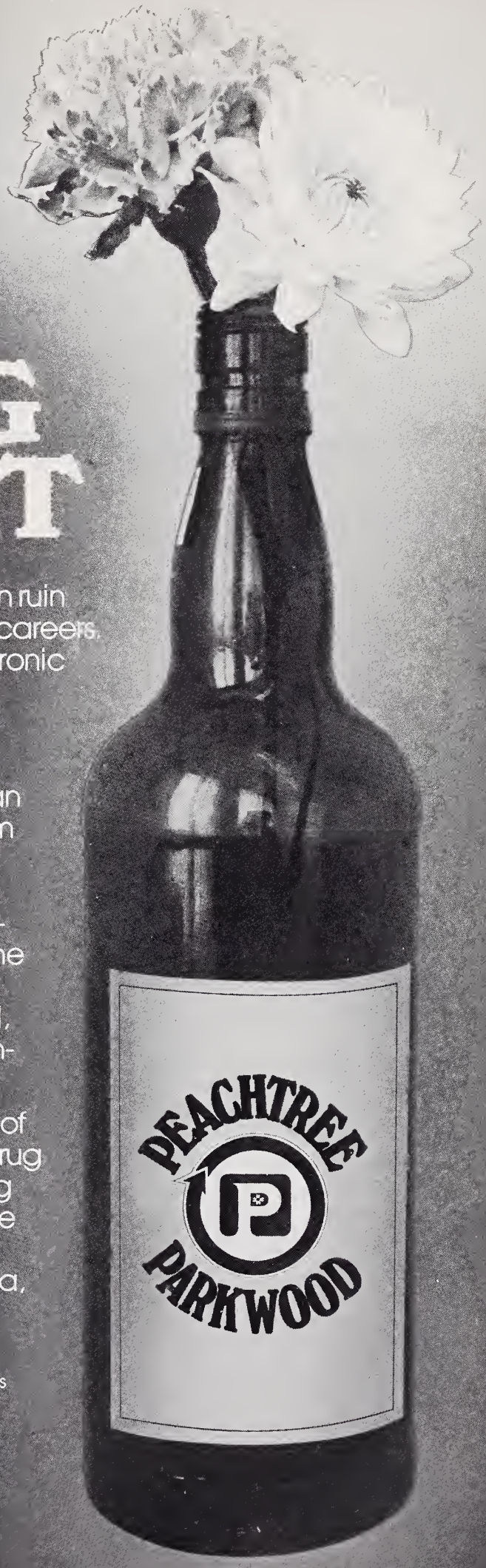
A SOBERING THOUGHT

Alcohol and other addictive drugs can ruin physical and mental health, families and careers. Because alcoholism is a complicated, chronic disease of the mind, body and spirit, the alcoholic is unable to overcome his or her problem alone.

Using a highly structured treatment plan — individualized for each patient — a team of physicians, nurses, alcohol/drug counselors and activity therapists at Peachtree and Parkwood's Alcohol and Drug Addiction Unit works with the patient to unravel the physical and emotional complications of chemical addiction. The Plan: withdrawal, individualized treatment and aftercare under close medical supervision.

Complete information on the services of Peachtree and Parkwood's Alcohol and Drug Addiction Unit may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

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"We must be aware of grave concerns about success and failure and how one may really be the other."

Human Response to Success and Failure

JAMES A. KNIGHT, M.D., *New Orleans, Louisiana**

HUMAN RESPONSE TO SUCCESS and failure is a broad topic and lends itself to many interpretations. Yet any facet of it can address, in a penetrating fashion, the human condition.

Success and failure can be defined in straightforward terms. Success is a favorable or prosperous termination of a venture, or a successful performance or achievement, while failure is the lack of success. Probably the clearest meaning of these two words emerge in everyday usage when we say: "That person is a success," or "that person is a failure." As regarding success, we often say: "He or she is a successful parent, teacher, doctor, or lawyer."

In the process of hiring Yale's flamboyant chaplain, William Sloane Coffin, to be pastor of New York's Riverside Church, someone asked him about his divorce from his first wife and his separation from the second. Coffin responded: "We don't learn from success. We learn from failures."[1]

At the outset, we must be aware of grave concerns about success and failure and how one may really be the other. For example, note the often quoted Biblical admonitions of how he that would be first shall be last and he that would be last shall be first, or he that would seek to save his life shall lose it and he that would seek to lose his life shall save it.[2]

In other words, both success and failure have many faces, and two persons, or society and a person, may each interpret a particular face quite differently. Ponder the following statements. John Masefield writes, "Success is the brand on the brow for aiming low." Rudyard Kipling promises the earth, "If you can meet with Triumph and Disaster/And treat those two imposters just the same." The English poet John Keats contends that "Failure is, in a sense, the highway to success." A. B. Alcott, early American educator, expresses a similar view: "We mount to heaven mostly on the ruins of our cherished schemes, finding our failures were successes." Albert Einstein defines success in terms of giving and receiving: "A successful man is he who receives a great deal more from his fellowman, usually incomparably more than corresponds to his service to them. The value of a man, however, should be seen in what he gives and not in what he is able to receive." Conrad Hilton, of the Hilton Hotel Chain, asks and answers a question: "What is this thing — success? It cannot be measured by the accumulation of money. Too many rich men are failures and too many poor men masters at the art of living to make this the criterion."[3]

"This . . . search for meaning . . . may help us change despair into hope . . . tears into laughter, and brokenness into wholeness."

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Victor Hugo had his own way of defining success. Once, when Hugo was 80, his teenage grandson found the old man making love to a young laundress. "Look," said Hugo proudly, "that is what they call genius."[4]

In discussing human response to success and failure, these facets of the topic attract my attention:

(a) Our response to success or failure relates to what meaning we see in, of, and beyond our actions and involvements.

(b) The fear of success — a widespread phenomenon in our society — may sabotage our deserved or expected victories.

(c) An awareness of whether a person sees his performance or actually his life as success or failure is crucial in understanding response.

(d) Furthermore, is there a general attitude, a stance, a basic philosophy of life that can guide one's response to success or failure and give one a sense of survival or continuity in all of life's happenings?

Meaning Seen in Endeavors

Our response to success or failure relates to what meaning we see in, of, and beyond our actions and involvements. This meaning or search for meaning is a task that confronts us all and may help us change despair into hope, helplessness into creative action, tears into laughter, and brokenness into wholeness.

Sir Thomas More, the brilliant English author, statesman and scholar, can be our teacher in this matter. More served as lord chancellor of England, the highest judicial official in that country but resigned from that office because he opposed King Henry VIII's plan to divorce Catherine of Aragon to marry Anne Boleyn. More was imprisoned and in 1535 was beheaded for refusing to accept the king as head of the English church. He was given the opportunity to be freed from prison, if he recanted what the King called treason. More's wife, while visiting her husband in the Tower of London before his execution, urged him to recant and return home with her to his family. These are her words:

"What the good year, Master More, I marvel that you, that have always been hitherto taken for a wise man, will now so play the fool to lie here in this close, filthy prison, and be content thus to be shut up amongst mice and rats, when you might be abroad at your liberty, and with the favour and good will of the King and his Council, if you would but do as all the Bishops and best learned of this Realm have done. And seeing you have at Chelsea a right fair home, your library, your books, your gallery, your garden, your orchard, and all other necessaries so handsomely about you, where you might in the company of me, your wife, your children, and your household be merry, I muse what in God's name you mean here still thus fondly to tarry."[5]

It was hard for More to answer his wife in a rational or pragmatic fashion, but he sought to prepare his wife and family for his death. Clearly he wanted to live, but the end of his life had to *mean* something, and was to be measured by more than what he had given up. He was arguably the greatest man of the sixteenth century, and he has become through the succeeding centuries a symbol for those who place their consciences above the claims of secular authority. Yet, his head was nailed to London Bridge.

"[One terminally-ill] clergyman . . . became a partner with the Lord in a fellowship of suffering and . . . found meaning . . . in his own death."

Recently I was asked to see a 9-year-old boy who had osteogenic sarcoma of the leg. He was depressed and was uncertain about submitting to further treatment. He had already lost one leg, and the cancer had spread to other parts of his body. His chance of living a year or two longer was slim indeed. He stated that when given his medicine he remained quite nauseated for a week. Then by the end of the following week when he had recovered from this nausea, he was usually given another injection of medicine — and his nausea returned. Thus, since he was sick essentially all the time, he had nothing to look forward to. "Why should I not go ahead and die?" he asked. We sat quietly for awhile and then I asked him, "Do you plan to take the medicine and if so, why?" He replied, "Yes, I plan to take it, because my mother wants me to." The meaning he saw in his action related to his mother, and the relationship to his mother helped him endure his pain and suffering and not give up. This was an immediate and close relationship, and his response to his illness and fate was anchored in this relationship.

A somewhat similar situation involved a tall, slender black clergyman who had cancer that could not be controlled medically. He realized that he had only a short time to live. In reminiscing about his past, he spoke of being reared in a foster home, for his mother had died when he was an infant. He went on to say how lonely as a child he had been on occasions such as Christmas, because he had no family. Then he grew up, fell in love, and married — and found in his family the fulfillment of his dreams. In describing the woman he married, he said: "I came to her table and was given the bread of heaven." In the final stages of his illness he spoke to his congregation and to others about how he saw his illness and his approaching death, how he was responding to what was happening, and what meaning

he saw in it. He stated that he had sought long and hard for meaning, for understanding in the matter, and that his Lord had given him the answer in an old and familiar hymn:

"Must Jesus bear the cross alone
And all the world go free?
No, there's a cross for everyone
And there's a cross for me."

This clergyman saw a redemptive quality in his suffering. He became a partner with the Lord in a fellowship of suffering and thereby found meaning, salvation, and healing in his own death.

Let us now examine response to an event different from the previous three life events described in this section — religious experience. Religious experience, a phenomenon not always understood in our culture, may evoke a response in a person that can heal or fragment, depending on how the person interprets the experience. Sometimes we ask whether the religious experience of a particular person is genuine or false, normal or pathological. In a sense, this is an inappropriate question. The focus should be on the reaction to religious experience and not on the experience, if we are to understand human behavior. The reaction to the experience can be either normal or pathological, and that is what should be emphasized. The great saint is honored because of the validity of his religious experience. On the other hand, the catatonic schizophrenic in a mental institution who stands frozen with an ecstatic expression on his face lifted to the sky is looked upon as having had a pathological religious experience. The religious experience of the saint and that of the person in the mental institution may be the same. The reaction of the saintly person was normal, and the reaction of the schizophrenic to his religious experience was, of course, pathological. The difference seems to be in ego strength. The strong person feels overcome by the presence of God within him, and he feels that he is becoming God or Godlike. He begins to think possibly that he is losing his mind, but then decides that this is too wonderful a thing to fall in the category of insanity. He begins to evaluate himself and possibly to search the Scriptures for an understanding of his religious experience. He finds in the Scriptures the testimony of people who declare that God liveth in them. Then he begins to integrate and fit the experience into his life. He is able to contain himself, for his head and his heart are strong enough to encompass this religious experience. On the other hand, the person with a somewhat weak ego feels the impact of such a religious experience and may immediately declare that he is God. He is overwhelmed by the experience, and his head and heart are not strong enough to contain the experience. He could become a babbling psychotic declaring himself God or frozen into a catatonic state with an expression of ecstacy on his face. The impact of a genuinely deep religious experience is almost always overwhelming. The whole history of man's encounter with God points this out. Time and again the prophets avoided hearing the voice of God, seeing Him, or letting Him get hold of them in any way, because they were afraid they could not contain themselves after such an encounter. This is illustrated beautifully in the Biblical books of Isaiah and Jeremiah.

"Often the underlying sense of failure in our lives is not caused by inability but by the fear of success."

The Fear of Success

Another matter crying for attention in any discussion of success and failure is a fairly widespread phenomenon in our society: the fear of success. Often the underlying sense of failure in our lives is not caused by inability but by the fear of success. To understand the fear of success, one must consider this variable of the personality in connection with two other adjacent variables, *the fear of failure* and *the wish to succeed.*[6]

The fear of success is an unconscious fear of what one consciously considers important and desirable. The person's unconscious fear may be that his success is not justified or that he is a fraud. The fear of failure, a conscious fear, may be defined as the fear that a person's incompetence will result in specific mistakes. The wish to succeed may be defined as a conscious drive for effective accomplishment of a particular task. The wish to succeed is a positive force while the fear of failure is negative and may interfere in the attempt to take necessary risks.

In Sigmund Freud's famous essay entitled "Those Wrecked by Success," he discussed some cases in which illness followed close upon the fulfillment of a wish and put an end to all enjoyment of it. Freud went on to say that his psychoanalytic work with patients has taught him that the forces of conscience which induce illness in consequence of success, instead of, as normally, in consequence of frustration, are closely connected with the Oedipus Complex, the relation to father and mother — as perhaps, indeed, is one's sense of guilt in general.[7]

Psychiatrists see many patients who practice self-sabotage and who cheat themselves of well-deserved success in almost any aspect of living. The following case is representative of this group.

A tall, handsome 39-year-old worker was referred because of tension headaches. His excellent command of language was impressive. Although his

formal education extended only through high school, his store of knowledge was great. He had many interesting hobbies, from organ building to collecting 19th century Springfield rifles. He was well informed in electronics and mathematics. The most impressive aspect of his life was that, although he had great ability and a sizable store of information, he was holding a mediocre job in an industrial plant — working in a toolroom. His assigned duties were not a challenge and probably did not require even a small portion of his skills. A review of his history revealed that on several occasions in different settings he had worked himself up to a promotion of a fairly high level and then had quit and sought another job. Frequently there were realistic factors in his quitting and moving, and at other times the factors did not seem realistic. This was the story of a man who sabotaged himself at critical periods in his advancement.

"Psychiatrists see many patients who . . . cheat themselves of well-deserved success in almost every aspect of living."

What does it mean when one practices this type of self-sabotage? Intensive and deep probing is often necessary to uncover such dynamics. Some of the commoner factors are fear of success because of what it means — such as leaving one's peer group through advancement and then running the risk of being rejected by fellow employees; fear of competition, which always exists when one moves into a more favorable work status; fear of increased responsibility and the greater possibility of failure; an unconscious desire to fail as a form of punishment for some real or fantasied wrong committed in the past; fear of overcoming and advancing beyond the father (this may sound strange, but it is fairly well documented in psychiatry that certain persons seem to hold themselves back so as not to surpass or at times equal the father's accomplishments although their potential is greater); deep feelings of inadequacy which come to the surface when a bigger job is offered — "This new job is a man's job and I am still a boy"; and a desire to fail as punishment of one's family toward whom he is hostile, for they use him only as "a work horse."[1, 6, 8, 9]

In working with persons who sabotage themselves, or fear success, it is not always possible or indicated to involve them in intensive psychotherapy. At times it can be helpful to point out some of the dynamic factors generally seen in self-sabotage, without direct application to the person with whom one is talking. This initiates a process of introspection which, when aided by brief psychotherapy, often uncovers some of the specific dynamics related to that person's failure. This is commonly the situation in working with students who are having difficulties in school and in their vocational or professional development.[10] In the case of the patient described here, early and serious hang-ups with the father operated to keep him from becoming more successful than the father. These hang-ups were identified, and the impact of the insight that he was probably unconsciously sabotaging his own advancement became a powerful stimulus for change. He assessed his working environment, began applying himself in a more creative and intelligent way, and in a matter of a few months earned for himself a major promotion to a job which challenged his ability and skills. As his work situation improved, his tension headaches diminished.

How the Person Sees His Life or Performance

An awareness of whether a person sees his performance or actually his life as success or failure is crucial in understanding response. A person may see his life as failure while others, and history itself, may see his life as success. On the other hand, one may perceive his life or an event in it as magnificently successful, while the world may see failure in his life and deeds.

Surely many who seek power and money and accomplish their goal view themselves as a success, although exploitation and greed may characterize their lives. Discerning members of society may see these people as failures when measuring them by traditional values.

Not infrequently in our work in psychiatry we see a person compelled repeatedly to choose partners who are extraordinarily attractive physically, and this quality vastly overrides other considerations. What kind of person has this type of need? Usually this type of person has a very defective image of his own body — that is, a subjective body image that is defective rather than a realistically defective body. Such a person requires an especially attractive partner to enhance his negative view of his own physical self. On a superficial level, this person and those around him may see his accomplishment as success. Possibly only the counselor or therapist is permitted

"A person may see his life as failure while others may see [it] as success. On the other hand, one may perceive his life . . . as magnificently successful, while the world may see failure. . . ."

to learn that this person's so-called success is a response to a sense of failure.

Thornton Wilder has written a beautiful one act play based on the Biblical story of John 5:1-4. The play is entitled "The Angel That Troubled the Waters."[11] The play deals with a physician who comes periodically and waits for the angel, hoping to be the first in the pool of Bethesda, and to be healed of his remorse. Everybody around the pool hopes to be the first when the angel troubles the waters.

"At times it can be helpful to point out some of the dynamic factors seen in self-sabotage. . . ."

The angel appears but blocks the physician just as he is ready to step into the water and be healed.

Angel: Draw back, physician, this moment is not for you.

Physician: Angelic visitor, I pray thee, listen to my prayer.

Angel: Healing is not for you.

Physician: Surely, surely, the angels are wise. Surely, O Prince, you are not deceived by my apparent wholeness. Your eyes can see the nets in which my wings are caught; the sin into which all my endeavors sink half-performed cannot be concealed from you.

Angel: I know . . .

Physician: Oh, in such an hour was I born, and doubly fearful to me is the flaw in my heart. Must I drag my shame, Prince and Singer, all my days more bowed than my neighbor?

Angel: Without your wound where would your power be? It is your very remorse that makes your low voice tremble into the hearts of men. The very angels themselves cannot persuade the wretched and blundering children on earth as can one human being broken on the wheels of living. In Love's service only the wounded soldiers can serve. Draw back.

Note: The person who was healed rejoiced in his good fortune and turned to the physician before leaving and said: ". . . But come with me first, an hour only, to my home. My son is lost in dark thoughts. I — I do not understand him, and only you have ever lifted his mood. Only an hour . . . my daughter, since her child has died, sits in the shadow. She will not listen to us. . . ."

I am hesitant to comment on Wilder's story, because one would not want to detract from its simple but eloquent message. At the same time, it is good to reflect on how those broken on the wheels of living may use their brokenness to help heal others. What a response! A good example of this is seen in the work of the members of Alcoholics Anonymous.

A Philosophy to Guide Our Response to Success or Failure

Is there a general attitude or basic philosophy of life that can guide our response to both success and failure and give us a sense of survival or continuity in all of life's happenings?

In the November 30, 1947, issue of the *New York Times*, there appeared a fascinating autobiographical sketch by Tennessee Williams.[12] His play "The Glass Menagerie" had been a success for the past three seasons, and he had been snatched out of virtual oblivion and thrust into sudden prominence. From the precarious tenancy of furnished rooms about the country, he had moved to a suite in a first-class Manhattan hotel. The sort of life which he had had previous to this popular success was one that required endurance, a life of clawing and scratching along a sheer surface and holding on tight with raw fingers to every inch of rock higher than the one caught hold of before. He described this struggle as a good life because it was the sort of life for which the human organism is created. Now in the plush circumstances of a fine hotel and servants to wait on him, he began to experience a spiritual dislocation, depression, and disenchantment. He realized that he had to escape from this effete way of life. How could he capture again something he had before success happened to him. He stated that once you apprehend the vacuity of a life without struggle, you are equipped with the basic means of salvation. He went on to say that once you know that the heart, mind, and body of a person are forged in a white-hot furnace for the purpose of conflict (the struggle of creation), you know that with conflict removed, the

"Beauty and nobility can spring from the human in health or in sickness, in success or in failure. The forgetting of self is the key."

person becomes a sword cutting daisies. Not privation but luxury is the wolf at the door, and the fangs of this wolf are all the little vanities, conceits, and laxaties that success is heir to. This kind of knowledge will help one avoid the catastrophe of success, according to Williams, and push aside the caresses of success which are often absolute protection, utter effortlessness, and security.

I find no fault with Tennessee Williams' counsel and join him in recommending it. It seems appropriate, however, to go a step further in analyzing struggle and in seeing it as a basic response to success or failure.

In a larger sense, a person's struggle relates to his efforts to transcend the limitations of his crea-

turehood. In this world he experiences a sense of estrangement, which is a necessary part of the human condition. Pride and self-inflation may lead him to attempt to become God in his effort to transcend his finitude. Once he grasps the meaning of his pride and self-inflation, and how they come from the self in the existential situation, he senses vividly the limitations of all human achievement and the ambiguity of all human virtue. Beauty and nobility can spring from the human in health or in sickness, in success or in failure. The forgetting of self is the key.

". . . the power of love is the key to healing a person's alienation and estrangement and to breaking down the barriers that separate him from his neighbor."

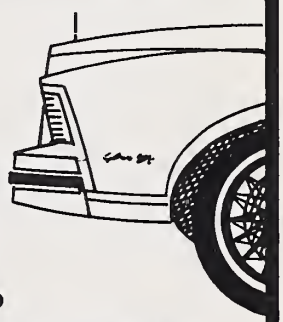
The ancient Greeks' familiarity with this forgetting of self is dramatically symbolized in the Homeric story of the wound and the bow, dealt with in Sophocles' great drama *Philoctetes*. A poisonous snake bites Philoctetes when he and his companions stop at Chrysa on their way to Troy. The wound refuses to heal, festers, and gives off a horrid odor. The repulsiveness of the wound, combined with Philoctetes' agonizing groans, lead his shipmates, at the instigation of Odysseus, to abandon him. When the ship stops at the lonely island of Lemnos, he is transferred to land while he is asleep, and his ship sails to Troy without him. Time passes and the Greeks learn through an oracle that they cannot win the war against Troy without the wonder-working bow of Heracles. As it happens, the wounded and abandoned Philoctetes has the bow in his possession. Odysseus assumes that the suffering and embittered Philoctetes will not part with the bow willingly. Thus he returns to Lemnos, hoping to secure the bow by trickery. Odysseus chooses Neoptolemus, an honest youth, to wheedle the bow from Philoctetes. Neoptolemus refuses to take advantage of him and reveals the plot. In spontaneous altruism, Philoctetes conquers his deep resentment and offers the bow to help his countrymen. The moment he bestows the gift, his "one talent," his wound is miraculously healed and he is able to take a crucial part in the siege of Troy.

The forgetting of self, or the power of love, is the key to healing a person's alienation and estrangement, to the breaking down of the barriers that separate him from his neighbor. He becomes a member of the larger human family and experiences a sense of solidarity with all mankind. That is what really matters; that is the response that is truly human; that is the response that is appropriate for success or failure — the response for all seasons.

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WE MAKE HOUSE CALLS.



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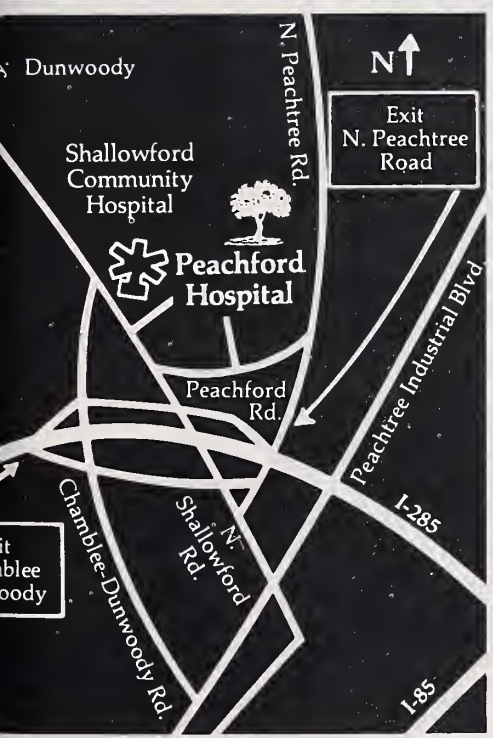
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president's letter



Cost Containment

COST CONTAINMENT means many things to many people, a noose around the physician's neck perhaps, but all segments of society are concerned, including hospitals, industry, labor, insurers, consumers, the medical profession, and last but not least, the federal government. Ironically, cost control is probably the strongest inhibitory influence against adoption of any radical "Kennedy-type" national health insurance to date.

Because of concern over costs, a number of objections have arisen, including assaults from the Professional Standard Review Organization, the Health Maintenance Organization, the Health System Agency, National Health Insurance, and the Federal Trade Commission, just to mention a few. Many factors are involved with increased costs and include: new technologies, new drugs, greater demand for all kinds of health services, greater availability of health insurance, high wages and prices paid by hospitals, added personnel and technical features, such as open-heart surgery, dialysis, organ transplants, major joint replacement, intensive care units, etc. The medical profession has accepted the challenge of cost containment. The American Medical Association (AMA) created and funded the National Commission on Cost of Health Medical Care composed of 27 members and representing all interested parties. Their recommendations are being considered. The voluntary program initiated by the AMA, the American Hospital Association, and the Federation of American Hospitals, along with insurance companies and Chambers of Commerce, have a 15-point program in operation. Goals include a reduction of 2% per year in hospital price increases and a moratorium in bed construction. The president of the AMA, Tom Nesbit, recently requested that physicians reduce their fees by 1% per year to go along with what hospitals are doing.

All this folderol, when our country is in a real state of emergency, with inflation galloping along at an annual rate of 10.4%. The consumer price index rose 11.2% from March through June 1978, and basic necessities, such as food, shelter, and energy, increased 15%. Only medical costs have slowed down from 8.7% to 7.5%.

Government deficit spending, the cause of inflation, is destroying this country. The present situation makes it impossible to provide for the future by private action. Personal savings, insurance, and pension funds can all be wiped out by accelerating inflation. The government bureaucrats on the other hand, because of periodic cost of living increases, run no risk short of a strike by the Bureau of Engraving and Printing. Unless the ship can be righted and a course set where Congress is forced to balance the budget, the stormy seas about us may well sink our ship — and not just

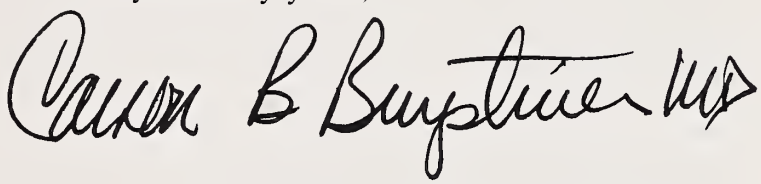
private medical practice as we know it but the United States as well. The AMA favors equitable protection against the cost of illness through insurance, which will keep the practice of medicine and the payment for medical services in the private sector. We are unalterably opposed to any program in which the federal government would be given the responsibility for financing and administering a taxpayer-subsidized national health insurance.

A very simple solution presented in a speech by Milton Johnson, M.D. would be to pass a law that forbids the federal government from spending more than 90% of its income each year, and that requires it to apply the remaining 10% towards the reduction of the staggering national debt. Coupled with this should be a provision that the federal government can pass no more tax revenue laws.

Senator Ted Kennedy said at the AMA Leadership Conference in January, "No federally enacted medical solution can be successful if it is resisted by the overwhelming majority of practicing physicians."

Gentlemen, the time has come for us to join together and resist.

Very sincerely yours,



Carson B. Burgstiner, M.D.
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One Opinion on Second Opinions

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The above, of course, is second opinion, "medical style." It is hard for us to walk in another's shoes, but hopefully, when you read this opinion, some of you may come to understand how many surgeons think and feel about "second opinion."

Voluntary second opinion has been with us for as long as we have had doctors. Whenever a patient is referred or a consultation asked for, a second opinion is, in fact, being requested. Any "second opinion" beyond this is either coercive or compulsory. We are seeing the results of millions of dollars of propaganda in an effort to influence the thinking of our colleagues and our patients and so coerce us into a variety of second opinion programs. It is unfortunate that every day we see people and organizations who apparently do not care where the train is going so long as they are in the locomotive. For example, the Prudential Insurance Company wants to keep its Medicare contract and still be first in line for whatever better comes along. The panel of surgical specialists of the Georgia Medical Care Foundation has expressed concern about mandatory opinions and yet offered to aid with a voluntary program. Similarly, Blue Cross/Blue Shield wishes to be listed as cooperative and available and is setting up programs where they can.

Why does the government want a second opinion program? Two of the reasons given are that it will discourage unnecessary surgery and contain cost. These reasons are given in spite of the facts that there is no real evidence that significant unneeded surgery is being done and that no pilot programs regarding costs have been completed. (The $800,000 savings claimed by New York Blue Shield have dwindled under questioning to one tenth of that.)

So what would such a program effect? From a governmental viewpoint many things: It could be used as a wedge between surgeons and other doctors. It would certainly disturb the traditional one-to-one patient-doctor relationship. Its effect on insurance companies has already been noted. But primarily, it would be a source of government control of both doctors and patients. It could be the framework for delaying surgery or for rationing surgical care, and it would likely be used for this purpose should a comprehensive National Health Insurance Plan be enacted.

Of the many interesting stories written by Dr. J. G. McDaniel, my favorite is the one about the wild hogs in the Arkansas swamp. They were finally trapped by placing food in the swamp night after night for weeks, then a pen was constructed, bit by bit, during the day around the food until finally the pen was

completed, and the trap was sprung. This program can be compared to that pen, and it can be modified and expanded at will, once agreed to in any form by surgeons.

In sum, the vast resources of the federal government have been committed to a program of coercive action to implement a method of control of surgical practice on the premise that unnecessary surgery is being done, and that money will be saved. An integral part of this is the assumption that the second doctor, who is looking to the government or an insurance company for his pay, will give a more objective and valid opinion than the first doctor. These premises are based on bias and are without substantive evidence. A complex bureaucratic process is envisioned to replace individual judgment with that of a committee, the majority of which would be representatives of the government. No consideration has yet been given to: the likelihood of damage from delayed treatment due to misplaced patient faith in a wrong second opinion; the increased confusion of patients who already have difficulty finding their way into and through the medical care system; the delay of needed referral to the surgeon by other doctors because of the realization that "Big Brother" is watching; and the many factors in the mutual decision of the physician and his patient to have surgery in hopes to better the quality of life of the patient. I see only a near term-decrease in quality of care, snowballing in the future as individual judgment is replaced by committee decision.

I was asked to write this as the President of the Georgia Chapter of the American College of Surgeons. I would not presume to supplant the individual decision of each surgeon. I cannot speak for the Chapter on such a matter; however, I will say this to my colleagues in Gainesville and hereabouts: "I am interested in the practice of medicine only. If you want me to consult with you about your patient, I will be glad to do so. If you want to get a first or second opinion about surgery, please send your patient elsewhere." I will say the same to my patients and the rest of the public. If enough feel as I do, there will be no second opinion programs.

P. K. Dixon, Jr., M.D., President
Georgia Chapter
American College of Surgeons

Editorial Correction

IN THE AUGUST EDITION of the *Journal* some erroneous data were presented in the editorial on Physicians' Assistants. It was stated that the number of physicians' assistants graduating from the Medical College of Georgia (MCG) this year is 61. Actually, this represents the total number graduating from both MCG and Emory, with 23 coming from MCG and 38 from Emory.

The Physicians' Assistants program at MCG is in its 7th year of operation. The total number of students enrolled per year has averaged 48 ± 1 (24 juniors; 24 seniors).

Another inaccuracy was the impression given that most of the financing was with state tax funds. From the beginning of the program, most of the financial support has come from the federal government. At MCG for the current year, $224,451 is budgeted as direct costs, with $57,638 provided by the State of Georgia through the University System. Thus, the cost to the state is $1,201 per student ($57,638 divided by 48), not the figure $9,791.66 per student in "state tax funds" as cited in the editorial.

I am indebted to Dr. William Moretz, President of MCG, for bringing these correct data to my attention.

Please accept my sincere apology for these errata.

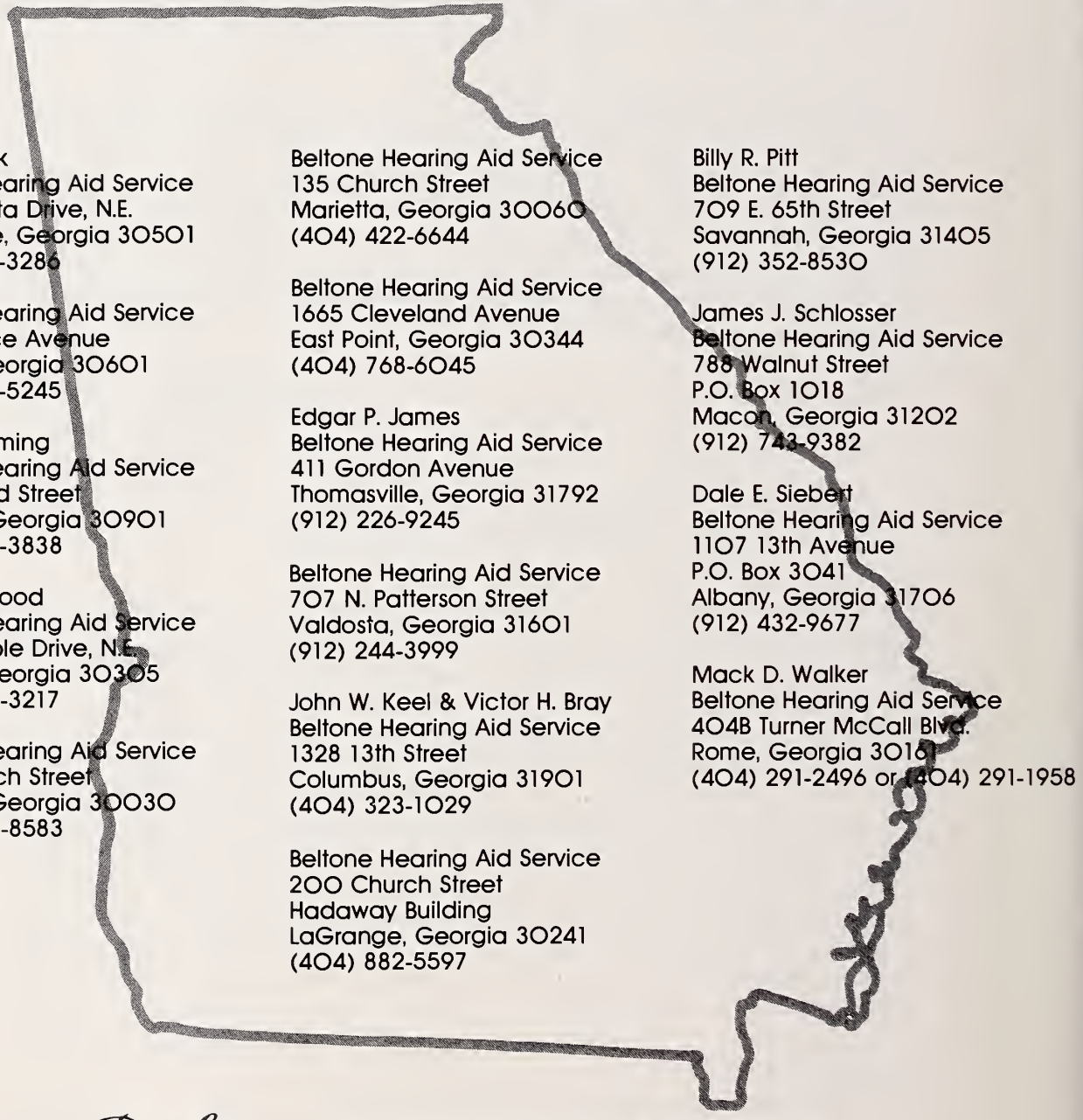
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Communication Is a Two-Way Process

BOB HOWARD*
Media Liaison Officer, U.S. Navy

"I am sure you heard what it was that I was saying, but I'm not sure you know what it is that I mean."

I heard a disturbing report several weeks ago which points out the communication problem which often exists between some doctors and their patients.

To make a long story short, the report indicated that some doctors were considering the use of videotape machines to document and verify their discussions with patients. It seems that the need for this procedure arose as a result of frequent complaints from patients that physicians were not communicating all the facts to them. Now, with the videotape at his disposal, the doctor could re-examine his discussion with the patient and see what information had been communicated.

As Struther Martin said to Paul Newman in the movie "Cool Hand Luke" after striking him in the back of the head with a club, "What we have here is a failure to communicate."

I do not think this failure is a problem perpetuated only by doctors. The patient who really insists on having all the facts about his case can get them. Both as patients and as members of the patient's family, we must remember that doctors are not mind readers. While it is true that sensitive and caring physicians do anticipate many of the questions we might ask, they cannot be expected to anticipate our every query.

I have spent a lot of time in the last several years sitting in hospital rooms with my wife, Debbie, who is an ovarian cancer patient. I would mull over the many questions I wanted to ask her doctor when he made his rounds. Invariably, he would enter with several residents in tow, and somewhere between hello, blood counts, changes in treatment, status reports, and small talk many of my questions would be forgotten. Five minutes after he had gone, I would remember my original questions as well as several more which had been prompted by his new observations or treatment changes. It was very frustrating. I finally solved the problem by writing down my questions and reading them to him, one by one, each time he visited Debbie's room.

At about the same time, I was hospitalized for a spinal fusion and still vividly remember my horrendous experience. A resident assigned to my ward spent a great deal of time warning me that if I did not urinate soon, he would have to "cath" me. I

*The author of this article is the husband of a cancer patient who was diagnosed as having stage three ovarian cancer 2½ years ago. The wife is doing very well. Recent surgery indicated the cancer is in complete remission. Prepared at the request of the American Cancer Society, Georgia Division. Others wishing to contribute papers to this department are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

had no idea what "cath" meant, but I knew it had to be better than exploding. I assumed it involved either taking a pill or getting a shot. My effort to relieve my condition was somewhat less than whole-hearted . . . after all, I knew I could always be "cathed." I cannot tell you what a blow it was to 1) my ego and 2) my modesty when an ancient nurse and three student nurses showed me what a "cath" was. The point, of course, is I failed the doctor, and he failed me. Had we taken the communication process one step further, with me asking and him explaining, the misunderstanding would not have occurred. I can assure you I would have performed like Niagara Falls had I known what was involved in a catheterization.

It takes a great deal of sensitivity to anticipate the questions and problems of patients and their families. The communication process between doctor, patient, family, and nurse is especially vital to the cancer patient because he or she is faced with the additional pressures and stigmas associated with their disease. Doctors and nurses must be always aware that they are dealing with patients and families who may be medically ignorant. These people may be afraid, embarrassed, or too overwhelmed to ask the questions that need to be asked. Questions must be solicited from patient and the family if total care is to be achieved.

Patients also have a responsibility to actively question their physician. They must learn about their condition so they can discuss their treatment and care. They should not assume anything; they should ask no matter how inane their question may seem to be. Communication is a two-way process, and if we are to be more effective as doctors, nurses, and patients, we must become adept at it.



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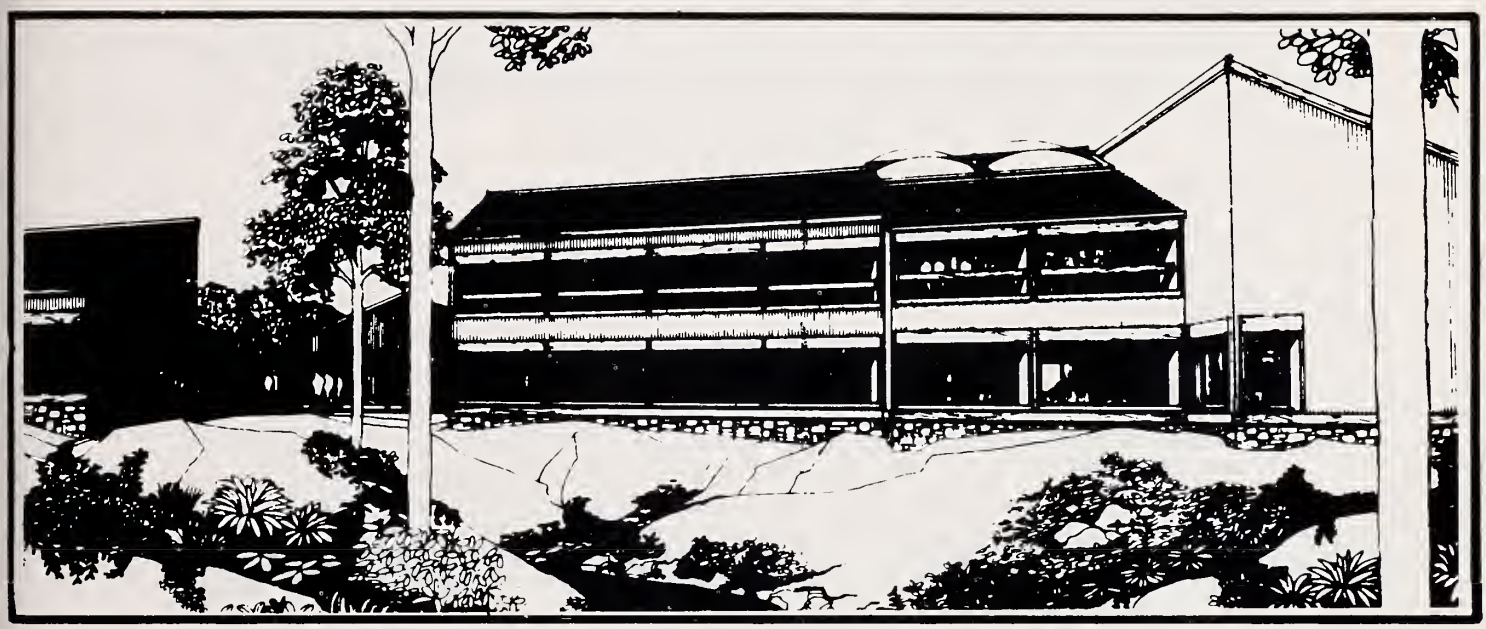
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Atherosclerosis: Prevention Based on Pathogenesis

JOHN DAVIS CANTWELL, M.D., *Atlanta**

Introduction

RECENT ADVANCES in our understanding as to the causes of atherosclerosis suggest multiple precipitating factors, indicate how clinical risk factors may be involved, and present guidelines in preventing this widespread disease.

Ross and Glomset[1] present convincing data that indicate four sequential steps in the development of atherosclerosis: endothelial injury, platelet reaction, medial smooth muscle cell (SMC) proliferation and secretion, and lipid accumulation.

Endothelial Injury

In the experimental setting, endothelial injury can be induced by a number of factors including hypercholesterolemia, hypertension, cigarettes (via carbon monoxide or decreased oxygen saturation), normal hemodynamic forces (tension, stretching, shearing, eddy currents, hyperviscosity), especially at branch points, stress (catecholamines), mechanical injury, immune reaction, hormonal dysfunction, and homocystinemia.

Wissler *et al.*[2] studied three species and found that endothelial injury from various causes will heal unless hyperlipidemia is present. They also observed that regression of atherosclerosis occurred in the Rhesus monkey when serum cholesterol levels were reduced below 150 mg/dl. On the other hand, they also noted that when feeding the monkeys small daily supplements of cholesterol, SMC proliferation occurred even though the serum cholesterol levels were not significantly elevated.

A study by Kottke and Subbiah[3] revealed that the White Carneau pigeon, which is subject to spontaneous development of atherosclerosis, experiences endothelial damage and platelet aggregation before the accumulation of lipids and the formation of plaques.

Platelet Reaction and Smooth Muscle Cell Proliferation

In response to endothelial injury, platelets aggregate and secrete such substances as mitogenic factor, adenosine diphosphate, serotonin, lysosomal enzymes,

*Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd. NE, Atlanta, Ga. 30324.

Dr. Cantwell is the Director, Preventive Cardiology Clinic, and Co-Director, Cardiac Rehabilitation, Georgia Baptist Hospital, Atlanta. His address is 229 Peachtree St., NE, Suite 201, Atlanta, Ga. 30303.

thromboxane A_2, and prostaglandins. One of the platelet factors (which is relatively heat-stable and nondialyzable) appears to trigger medial SMC proliferation, migration, and secretion. Lipoproteins and insulin appear to play a supportive role in SMC proliferation. The SMC secretes collagen, elastic fibers, and glucosaminoglycan, and these substances bind low density lipoprotein (LDL) which is taken up across the injured endothelial area.

Humans who have homocystinemia often experience premature atherosclerosis. The latter can be reproduced in the baboon given an elevated homocystine level. Homocystine appears to injure the endothelium and trigger the SMC proliferation and decrease in platelet survival time. When the animals were given dipyridamole (Persantine), the endothelial injury still took place, but the SMC proliferation did not, presumably because of the drug's antiplatelet effect.[4] Endothelial injury and decreased platelet survival have also been observed in monkeys who had induced chronic hypercholesterolemia.

Humans with Von Willebrand's disease have impaired platelet function, and are felt to infrequently develop significant atherosclerosis. Pigs with this same genetic disease are resistant to the development of atherosclerosis, possibly because of the platelet dysfunction.

Lipid Accumulation

Since the early stages of human plaque do not contain much lipid, this suggests that factors other than lipid infiltration may be precipitating factors. In some advanced plaques, 65% of the dry weight of the plaque is lipid (cholesterol, cholesterol esters (CE), and to a lesser extent, phospholipids like lecithin and sphingomyelin). Studies on terminally ill patients showed that most of the free and esterified cholesterol in plaques was derived from plasma.

The cellular mechanisms of lipid accumulation were lucidly reviewed by Small,[5] and the following sequence of events was demonstrated:

1. LDL is taken up at special receptor sites.
2. CE attach to lysosomes within the cell which hydrolyze the CE into free cholesterol and fatty acid. The latter can enter stored triglyceride droplets.
3. The free cholesterol can (a) block hydroxy methylglutarate, turning off intracellular synthesis of cholesterol, (b) stimulate formation of CE by the acyl coenzyme a: cholesterol acyltransferase system, and (c) suppress formation of the membrane receptor sites.
4. Free cholesterol can be removed from the cell by high density lipoprotein (HDL) at the surface of the cell or, via the lecithin-cholesterol acyltransferase system, can be converted to CE, which leaves the surface of the cell to form the core of HDL.

Consideration of the complexity of intracellular cholesterol metabolism gives one an appreciation of several mechanisms that could contribute to accelerated atherosclerosis, such as:

1. Excessive levels of LDL, which could overwhelm the system,
2. Deficiency of membrane receptor sites (as in familial hypercholesterolemia),
3. Unsuppressed intracellular cholesterol synthesis, and
4. Insufficient levels of HDL, which may be important in removing cholesterol from the cell and limiting LDL entry into the cell.

Practical Considerations in Prevention

It would seem prudent to reduce or eliminate factors that are known to injure the endothelium. Lipid levels and blood pressure can be controlled, cigarette smoking can be eliminated, and stress can be reduced. Certain hemodynamic factors, such as blood viscosity, can be improved by vigorous exercise.

The platelet sequence (Figure 1)[6] can be interrupted by aspirin, which inhibits cyclo-oxygenase and thereby prevents formation of thromboxane A_2 which contributes to vessel spasm, platelet aggregation, and platelet release. Persantine blocks phosphodiesterase, thereby increasing cyclic adenosine monophosphate

(cAMP) levels which inhibit platelet aggregation. Sulfinpyrazone (Anturane) is a competitive inhibitor of prostaglandin synthesis; it may inhibit the release reaction and may also protect the endothelium against injury. Vigorous exercise may also decrease platelet aggregation.

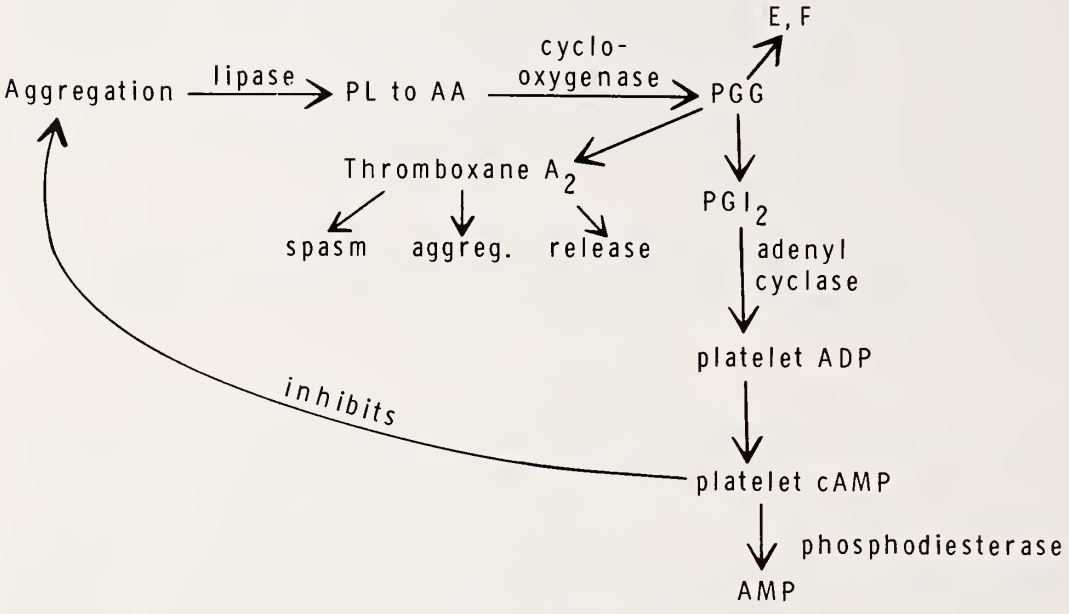


Figure 1. Platelet mechanisms. Aspirin inhibits cyclo-oxygenase, Persantine blocks phosphodiesterase, and Anturane is a competitive inhibitor of prostaglandin synthesis and may also inhibit the release reaction. Figure modified from Weiss (6). PL = phospholipid, AA = arachidonic acid, PG = prostaglandin.

Preliminary studies[7-9] suggest that aspirin, Persantine, and Anturane should be considered in coronary and stroke prevention, for coronary bypass graft patients (hoping to decrease platelet activity that may contribute to graft deterioration), and in those at high risk for sudden death.

The decreased platelet survival seen in coronary patients is improved by coronary bypass surgery, by aspirin plus Persantine, and by reduction of lipids. Platelet survival is shortened in those with saphenous vein graft occlusion.[10, 11]

Diets low in saturated fats and refined sugar (similar to Japanese cuisine), in conjunction with new lipid lowering agents (such as colestipol) may help in the lipid phase of atherosclerosis. Regression of atherosclerosis or at least prevention of progression, has been documented in several studies and is a realistic goal, even though it requires an aggressive approach.[12, 13]

Elevated HDL levels play a protective role in atherosclerosis and are seen in those who engage in distance running[14] and in those who use alcohol in moderation.[15] The entities, familial hyper-alpha-lipoproteinemia and familial hypobetalipoproteinemia, may be associated with absence of significant atherosclerosis[16] and with longevity.[17]

New Areas of Study

A. Pathogenesis

Other genetic and/or environmental factors may also contribute to atherosclerosis. For example, autopsies on children under the age of 1 year revealed that the inner coronary vascular layers are thicker in those from Eastern Finland (the "heart attack capital of the world") than in those from Western Finland.[18] Why?

What role do intimal cushions play in atherosclerosis? They have been described in the epicardial coronary arteries of newborn infants, occurring in regions of vessel fatigue which are the most susceptible to plaque formation, and are up to three times as common in males as compared to females. Are they a factor in sex differences in the prevalence of coronary disease?

B. Therapy

A prostaglandin known as prostacyclin, or PGX, is a potent inhibitor of platelet aggregation and a vasodilator. Are there ways to increase its production in the body?

Aspirin does not convey the same protective effect against certain forms of cardiovascular disease in men as it does in women. Why?

An antibody has been produced to the SMC growth factor from platelets. Could this be used clinically to interrupt the process of atherosclerosis?

Perhaps new drugs can be developed that act at different sites in intracellular cholesterol metabolism, decreasing production and uptake and facilitating removal.

Summary

New concepts in the pathogenesis of atherosclerosis are discussed, along with the relationship to preventive measures. Several areas that merit future study are highlighted.

Atherosclerosis remains a devastating disease. We may be closer to an understanding of its cause and prevention than we realize.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

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Third-Party Reimbursement Programs— Are They Immune From Antitrust Attack?

ROBERT N. BERG, *Atlanta**

In recent years, there has been a significant increase in antitrust litigation challenging various aspects of third-party health care reimbursement programs. For example, both individual and institutional health care providers and private insurance carriers have claimed that certain reimbursement arrangements involve illegal price discrimination under the federal antitrust laws (the "Antitrust Laws"). The most frequently challenged arrangements provide that a policyholder is reimbursed at a higher rate for utilizing the services of a "participating" physician or hospital (i.e., a physician or hospital which has entered into a provider arrangement with the insurance company) than for utilizing the services of a "nonparticipating" physician or hospital. Other suits have objected to the price fixing inherent in the practice of reimbursing physicians or other providers on the basis of a fixed schedule of maximum fees.

All of these and other similar lawsuits raise the question of the extent to which the health care reimbursement activities of insurance companies are exempted from the application of the Antitrust Laws under the "business of insurance" exemption contained in the McCarran-Ferguson Act. Predictably, courts have not agreed on the answer to this question.

The McCarran-Ferguson Act

The McCarran-Ferguson Act,[1] passed by Congress in 1945, was intended to "give support to the existing and future state systems for regulating and taxing the business of insurance"[2] by exempting the "business of insurance" from regulation under the Antitrust Laws to the extent such business is regulated by state law.[3] This exemption is limited, however, in that it does not preclude the application of the Sherman Act[4] to the "business of insurance" to the extent that there is present "any agreement to boycott, coerce or intimidate, or [any] act of boycott, coercion, or intimidation."[5] In other words, activities undertaken by insurance companies are exempted by the McCarran-Ferguson Act from regulation under the Antitrust Laws if these activities are within the "business of insurance" and are regulated by state law, and if these activities do not constitute a plan or act of boycott, coercion, or intimidation.

The "Business of Insurance"

The Supreme Court has stated that the "business of insurance" includes the relationship between the insurer and the insured, the type of policy which could be issued, its reliability, interpretation and enforcement, and other activities of insur-

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, general counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

ance companies which are closely related to their status as reliable insurers.[6] Within these general guidelines, however, lower courts have disagreed as to whether certain activities conducted by insurance companies in connection with the provision of health care services constitute the "business of insurance."

For example, in *Manasen v. California Dental Services,*[7] eleven practicing dentists brought an action against a non-profit organization which administered prepaid dental care plans, alleging that these plans violated Section 1 of the Sherman Act.[8] The thrust of the plans was that the practicing dentists who performed professional services under the plans were classified by the administrator of the plans as either "participating" or "nonparticipating" dentists. In order to be classified as a "participating" dentist, a practitioner had to submit a fee schedule to the administrator, which schedule would only be approved if the charges for certain designated procedures were below a specified maximum level. Moreover, to qualify as "participating," a dentist had to agree both to look solely to the administrator for reimbursement for dental care and services performed on patients covered by the plans and not to charge any such patient for any differential between the approved charge and the fee which the dentist would normally charge had there been no restrictions imposed under the plans. Finally, under the plans, a patient would receive full reimbursement from the administrator for services performed by a "participating" dentist; conversely, a patient who utilized the services of a "nonparticipating" dentist would receive less than full reimbursement.

The District Court for the Northern District of California found that the plans constituted the "business of insurance" and were thus exempted by the Act from attack under the Sherman Act. The Court reasoned that the level of fees and the payment arrangements between the administrator and its dentists were "critical elements in the administrator's contractual agreements with its subscribers"[9] and were "intimately related to the interpretation and implementation of [the administrator's] policies and [its] reliability as an insurer."[10]

The Fifth Circuit Court of Appeals reached the opposite conclusion in *Royal Drug Company, Inc. v. Group Life and Health Ins. Co.*[11] Several independent pharmacy owners brought suit against Blue Shield, challenging Blue Shield's plan of operation in connection with certain prescription drug insurance policies. Pursuant to this plan, if the pharmacy selected by a policyholder had entered into a written provider agreement with Blue Shield, the policyholder was required to pay only $2 (the "deductible" amount set forth in the policy) for the prescription drugs. Alternatively, if the policyholder used a nonparticipating pharmacy, he was required to pay the full price charged by the pharmacy and then apply to Blue Shield for reimbursement — and even then Blue Shield would only reimburse for 75% of the usual and customary charge for the prescription.

The Fifth Circuit held that the Blue Shield plan was not part of the "business of insurance."[12] Initially, the Court stated that the crucial determination was not whether the activities complained of were conducted by an insurance company, but was whether or not the activities complained of, even though conducted by an insurance company, were so closely related to the relationship between the insurance company and its policyholder as to constitute the "business of insurance." Thereafter, the Court determined that the Blue Shield plan was not part of the "business of insurance," in that it went beyond Blue Shield's obligations as an insurer and placed it in the business of providing products and services. In other words, while Blue Shield's agreements to provide protection against the risk that its policyholders would require pharmaceuticals were part of the "business of insurance," Blue Shield was neither obligated nor required and hence went beyond the "business of insurance" when it "sought to guarantee the provision of services on a 'cost-plus' basis or any other basis which might be more economical than the retail purchase of such product."[13]

Conclusion

There are still conflicting answers to the question of what constitutes the "busi-

ness of insurance." On the one hand, there is case law precedent to support the position that activities such as the differential reimbursement arrangements and the fixed schedules of maximum fees, as discussed above, are not within the "business of insurance," in that these arrangements are basically concerned with the relationship between the insurer and its providers and only peripherally related to the relationship between the insurer and its policyholders. Conversely, there is case law support for the position that these activities are directly related to the insurer's status as a "reliable insurer" and are thus within the "business of insurance." Consequently, until such time as the Supreme Court resolves the conflict created by these differing positions, it is unclear exactly when the "business of insurance" becomes the business of the Antitrust Laws.

Notes

1. 15 U.S.C. §§1011-1015.
2. *Prudential Insurance Co. v. Benjamin,* 328 U.S. 408, 429-430 (1946).
3. Courts have interpreted the "state regulation" requirement with considerable breadth, and, in most cases, have found that some type of state regulation was in existence. See, e.g., *Doctors, Inc. v. Blue Cross of Greater Philadelphia,* 431 F.Supp. 4 (E.D. Pa. 1975) (Pennsylvania Non-Profit Hospital Plan Act); *Crawford v. American Title Insurance Co.,* 518 F.2d 217 (5th Cir. 1975) (Alabama Insurance Trade Practice Act). In addition, Courts have held that the state regulation need only be in existence and need not be effective or enforced. See, e.g., *Ohio AFL-CIO v. Insurance Rating Board,* 451 F.2d 1178 (6th Cir. 1971).
4. 15 U.S.C. §1.
5. For the most recent Supreme Court decision interpreting the "exception within the exemption" for plans or acts of boycott, coercion or intimidation, see *St. Paul Fire & Marine Ins. Co. v. Barry,* No. 77-240, 46 U.S.L.W. 4971 (June 29, 1978).
6. *SEC v. National Securities, Inc.,* 393 U.S. 453, 457-461 (1969).
7. 424 F.Supp. 657 (N.D. Cal. 1976).
8. Section 1 of the Sherman Act provides, in pertinent part, that "(e)very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is declared to be illegal."
9. 424 F.Supp. at 666-667.
10. See, also, *Travelers Ins. Co. v. Blue Cross of West. Pennsylvania,* 481 F.2d 80 (3rd Cir. 1973), *cert. denied,* 414 U.S. 1093 (1973); *Anderson v. Medical Service of the District of Columbia,* Civ. No. 73-470-A (E.D. Va. February 10, 1976), *aff'd,* 551 F.2d 304 (4th Cir. 1977); *Nankin Hospital v. Michigan Hospital Service,* 361 F.Supp. 119 (E.D. Mich. 1973) ("The basic function of Blue Cross of providing pre-paid hospital care is clearly 'the business of insurance,' and the negotiation of contracts with providers constitutes 'acts in the conduct' of such business.").
11. 556 F.2d 1375 (5th Cir. 1977), *rehearing en banc denied* 564 F.2d 98 (5th Cir. 1977).
12. The Fifth Circuit reversed the lower court's determination that the Blue Shield plan directly related to its status as a "reliable insurer" and that the plan entailed the performance of the insurer's obligations owed to its insureds under the insurance contracts and nothing more. See 415 F.Supp. 343 (W.D. Tex. 1976).
13. See, also, *Battle v. Liberty National Life Ins. Co.,* 493 F.2d 39 (5th Cir. 1974).

Radioimmunoassay Laboratory at Yerkes Regional Primate Research Center

A new radioimmunoassay laboratory has been established at Yerkes Regional Primate Research Center of Emory University. The laboratory will serve the entire center in a variety of research projects, such as those which measure hormone levels in test animals. Dr. Michael S. Blank will serve as assistant neuroendocrinologist in the new laboratory under technical supervision of Dr. Delwood Collins, professor of medicine (endocrinology), Emory School of Medicine. Three-year funding for the radioimmunoassay laboratory has been provided by a supplemental grant of $86,880 from the Animal Resources Branch, Division of Research Resources, National Institutes of Health.

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Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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SOCIETIES

The meeting of the **Ninth District Medical Society** was held September 19 at Big Canoe, Georgia. In addition to the usual scientific meeting, election of new officers was held. Dr. Marcus Mashburn from Cumming, Georgia, is the president-elect, and Dr. Lamar Waters from Clarkesville is secretary-treasurer-elect. Also in attendance was MAG's president, Dr. Carson Burgstiner.

At its October meeting, the **Bibb County Medical Society** heard Jacques Caldwell, M.D., Chief of Clinic Immunology and Rheumatology at the University of Florida, Gainesville, Florida, speak on "Current Concepts in the Diagnosis and Treatment of Common Arthritides." Special guests were Earnest Atkins, M.D., and Jim Skinner, M.D., who were on hand to answer questions regarding MAG.

On October 10, the second of three public forums on heart disease was presented by the **Cobb County Medical Society** at South Cobb High School. Panel participants for the evening were: Wayne Templeton, M.D., Klaus Rees, M.D., Richard Hagood, M.D., Ken Thomas, M.D., and Richard Hammonds, M.D. The forums are designed to educate the public on the cause, prevention, and treatment of heart disease. As an added attraction, free blood pressure tests were given for persons attending the forum. The third and final forum is scheduled for November 14 at Dodgen Middle School. This is a public service by the Cobb County Medical Society, and all forums are free.

The **Muscogee County Medical Society** held a barbecue in September at the Green Island Country Club in Columbus to welcome the new physicians and their wives who moved into the community in the summer. Dr. and Mrs. Earnest C. Atkins, President-Elect of MAG, Dr. Richard A. Griffin, III, Second Vice-President for MAG, and Mr. Tom Sawyer of the MAG staff were special guests at this function.

Third District of Georgia Congressman, Jack Brinkley, spoke at a joint meeting of the Muscogee County Medical Society and the Auxiliary to the Muscogee County Medical Society at their October meeting. The event, which is an annual affair, was held at the Harmony Club in Columbus.

PERSONALS

Third District

H. Anderson Wasden, III, M.D., has moved his practice from Columbus to Warm Springs, Georgia. He is one of five physicians presently located in Meriwether County serving a population of 25,000 to 40,000. Besides enjoying the cleaner, more wholesome atmosphere in the country, this move has another advantage — easy access to the fish in Flint River.

Fifth District

James C. Crutcher, M.D., has been named chief medical director of the Veteran's Administration. This is the top administrative position of the nation's largest medical system.

Dr. Crutcher served as a pharmacist mate in World War II and as a battlefield surgeon in Korea in the Army Medical Corps. He rose to the rank of brigadier general while serving in the Army Reserve during the Vietnam war.

After military duty in Korea, he joined the Atlanta VA Hospital. During a 26-year career, Dr. Crutcher has held a variety of positions in the VA program on both the local and national levels.

John F. Kiser, executive director of the Medical Association of Atlanta, has been designated a Certified Association Executive (CAE) by the American Society of Association Executives (ASAE).

The designation was conferred at the recent ASAE Convention in Boston, Massachusetts. Mr. Kiser is one of 16 association executives in Georgia who have qualified for the designation through examination, experience, and meeting prescribed standards of professional conduct and performance.

Seventh District

Veeni S. Kumar, M.D., has opened her office for general medicine practice with a full-service laboratory at the Douglasville Village Shopping Center. Dr. Kumar received her M.D. degree from Punjab University in India and completed her postgraduate work at Emory University in Atlanta. She is also a diplomate of the American Board of Pathology.

Ninth District

Roger Martin, M.D., has joined the staff at the Northeast Georgia Medical Center. Dr. Martin is a graduate of the University of Georgia and the Medical College of Georgia, where he completed his internship and residency in obstetrics and gynecology. He has been in private practice in Chattanooga, Tennessee, for the past year.

John B. O'Neal, III, M.D., has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Kahlid Saeede, M.D., is going into practice with Drs. Hanks, O'Neal, and Poon in Elbert County.

DEATHS

William Henry Fulmer

William Henry Fulmer, M.D., died September 14 at Candler General Hospital. He was 62.

Dr. Fulmer was born in Savannah, the second son of former Savannah mayor, Olin F. Fulmer. He attended Duke University where he received his A.B. degree in 1937 and his M.D. degree in 1940.

In July 1942, Dr. Fulmer was inducted into the Army Air Corps as a lieutenant and spent 2 years on the Robins Field surgical staff in Macon. He received a battle star during a 9-month tour overseas in the Orient.

After his discharge in April 1946, he returned to Savannah to become house physician for Telfair Hospital. One month later he opened his own office and began his 32-year career. Dr. Fulmer served on the medical staffs of Candler, St. Joseph's Hospital, and Memorial Medical Center, and was a member of the Georgia Medical Society, Georgia Academy of General Practice, AMA, American Association of Family Practice, the Royal Society of Health, and the MAG. In 1960 he was named president of the First District Medical Society.

Survivors include: his wife, Mrs. Mary H. L. Fulmer, five daughters, a son, a step-daughter, a step-son, two sisters, a brother, and ten grandchildren.

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Fly by chartered World Airways jet to Egypt and the Greek Isles ... two of the world's most sought after destinations in one great deluxe trip. Six days in **Cairo** at the Nile Hilton Hotel. See the Pyramids and Sphinx. A visit to Luxor/Karnak and the Valley of the Kings is available. Then a six day cruise aboard Sun Line's **Stella Maris** from Athens to Santorini, Kusadasi/Ephesus, Rhodes, Kos and Hydra. Enjoy being pampered for two weeks — you won't want to come home.



Danube River Adventure

(Twelve days; September 3, 1979)

Via chartered Pan Am Jet Clipper to Vienna for a cruise down the beautiful Blue Danube aboard the brand new **m/s Ukraina.** Visit Bratislava, Czechoslovakia; Budapest; Hungary; Belgrade, Yugoslavia; Vidin, Bulgaria; Giurgiu and Bucharest, Romania; and the Russian port of Izmail. Transfer to the seagoing liner **m/s Ayvazovskiy** for a Black Sea cruise to Istanbul where you will enjoy one night amidst mosques and minarets.



Rhine River Adventure

(Eleven days; July 3, 1979)

Via chartered jet to the heartland of Europe. First, three days in exciting **Brussels.** See 17th-century Grand Place. Visit Ghent and Bruges. And enjoy fine Belgian cuisine. Next, three days aboard the **m/s Britannia** cruising to Dusseldorf, Cologne, Konigswinter, Braubach, Rudesheim, Gernsheim, Mannheim and Karlsruhe. Then experience the gemutlichkeit spirit of **Munich** for three days. Admire the breathtaking Bavarian Alps. Delight in tasty German food, beer and wine. Go cuckoo over clocks and watches of endless variety. Enjoy friendly people, new experiences and scenery that's hard to supass anywhere in the world.

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Please send me more information on:

- ☐ Egypt/Greek Isles Air/Sea Cruise
- ☐ Rhine River Adventure
- ☐ Danube River Adventure

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Endocrine Events at the Time of First Pregnancy

Emory Medical School researchers from the Division of Endocrinology issued a call for 200 women volunteers to help doctors learn how to protect women against breast cancer.

"Research shows women who have their first baby before age 22 are less likely to develop breast cancer. We need to know why so we can learn to protect all women from the disease," said Victoria Musey, M.D., chief clinical investigator of the First Pregnancy/Breast Cancer Protection Study.

"Breast cancer is now the leading cause of cancer mortality in women. The incidence has been increasing dramatically throughout the nation and especially in the five-county metro Atlanta area," Dr. Musey reports.

This is the only such project in the nation and is of major importance locally since the reasons for rapidly increasing rates of breast cancer are not known.

Researchers from Emory's Departments of Medicine and Biometry began the project last May with some 30 volunteers. However, 200 more women who are planning to have their first babies within the next 18 to 24 months are needed now. Volunteers must be healthy, between the ages of 18 to 22 or 30 to 40; must never have taken the pill; never been pregnant; have a regular menstrual history and must be planning to have a first baby soon.

Women interested in joining the fight against breast cancer are asked to phone (404) 588-3325 for full information about the tests they will take and how they will benefit.

Pfizer's Comprehensive Certificate of Need Assistance Program Available to Hospital Administrators

A new Certificate of Need (CON) Assistance Program is being offered to hospital administrators and the hospital community, according to Dr. Sheldon G. Gilgore, President, Pfizer Pharmaceuticals & Diagnostic Products, Pfizer, Inc. A toll-free telephone consultation service, which is part of this Comprehensive Assistance Program, will offer the hospital administrator direct and immediate access to expert consultation on the medical needs and cost effectiveness of major diagnostic equipment and the relevance of this information to CON.

The CON, one of the primary federal and state regulatory requirements, is usually needed whenever plant improvements or major capital equipment expenditures involve government health care funds. Filing for a CON can be a complex and time-consuming process, and the hospital administrator's task is further complicated by the fact that CON programs vary significantly.

Another important aspect of Pfizer's CON Assistance Program is the book, "Certificate of Need: An Expanding Regulatory Concept." This 944-page book — provided complimentary to the hospital administrator by Pfizer — is a comprehensive, state compilation of CON requirements. The text will provide additional support for major capital equipment procurement decisions.

This vital reference source, together with the toll-free telephone service, will allow the hospital decision maker purchasing Pfizer and any other manufacturers equipment to cope more effectively with the complex CON regulatory machinery. The convenient CON service can be reached from 9-5, Monday through Friday, by dialing toll-free (800) 638-9690.

Georgia Dietetic Association Publishes New Diet Manual

The Georgia Dietetic Association (GDA), Inc., Diet Therapy Section, in cooperation with Georgia Department of Human Resources, Division of Public Health, has published a new diet manual. It is designed for use in nursing homes, small community hospitals, local health departments, and other health facilities. The GDA DIET MANUAL features: principles of each normal and modified diet, foods included and excluded, and a suggested meal plan; the vegetarian diet; the revised Diabetic Exchange Lists; growth charts with reference percentiles for children; approximate composition of selected formulas and dietary supplements. This information is based on the most recent data available from the National Research Council's Food and Nutrition Board, the American Heart Association and The American Diabetes Association.

Copies of the GDA DIET MANUAL are available for $10.00 each, plus an additional $2.00 for the shipping and handling of each manual. Send your order to: Mr. Jim Short, GDA Central Office, 5019 Montclaire Rd., Stone Mountain, Georgia 30087.



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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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See package insert for complete prescribing information.

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A New Member Joins the MAG Staff

On September 22, 1978, Susan J. Dillon joined the MAG staff as the Managing Editor of the *Journal,* replacing Sharon T. Smith who had held the position for almost 2 years.

Born and raised in Arizona, Ms. Dillon attended Duke University in Durham, North Carolina, and the University of Nottingham in England. She completed her undergraduate studies at the University of Texas at Austin, where she received a Bachelor of Arts degree in English.

Ms. Dillon worked at the Center for Disease Control (CDC) in Atlanta for nearly 2 years as the Managing Editor of their *Morbidity and Mortality Weekly Report.* More recently, she was employed by the CDC as a writer-editor to compile and edit the 1977-78 report to Congress entitled, "The Health Consequences of Smoking." (So the only smoke you're likely to see in her office is that from midnight oil!) She is a member of the Cathedral of St. Philip.

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SUSAN KATZ DESIGN ASSOCIATES

Physician Recruitment Conference/ Pre-Practice Seminar

SEPTEMBER 29-OCTOBER 1, 1978

CALLAWAY GARDENS, PINE MOUNTAIN, GEORGIA

If one measure of success is enthusiasm, then that exhibited by the communities and physicians involved in the second Physician Recruitment Conference/Pre-Practice Seminar at Callaway Gardens would certainly qualify that event as a great success. The conference was jointly sponsored by the Medical Association of Georgia (MAG) and the Southeastern Institute for Community Health (SICH), Inc., of LaGrange, Georgia. Seventy physicians and their spouses were in attendance at Callaway Gardens between September 29 and October 1. Most of the physicians were second or third year residents in family practice, internal medicine, or pediatrics from Georgia and Alabama; 15 were from Tennessee, South Carolina, North Carolina, or Florida. A total of 45 communities representing hospitals, municipalities, or medical practice groups from non-urban communities in Georgia and Alabama also attended. The conference was partially supported by a grant from the Callaway Foundation, Inc., of LaGrange to SICH.

This conference was designed to provide information to non-urban communities about physician recruitment and to provide them with the opportunity of making contact with many physicians who will soon be looking for practice sites. The program for the physicians provided information generally not available to them within their training program about entry into practice, particularly non-urban practice. With both communities and physicians in attendance, a job market was created, giving both groups a chance for initial contacts. In many of the displays set up by the communities, both printed information and audio-visual material about the community were available. The physicians had an opportunity to talk with community representatives about practice potentials in their communities.

The first day of the conference, Friday, provided the communities with an overview of the resources available for physician recruitment, including the MAG placement service. Workshops were held early Friday afternoon for small group discussions by community representatives, and then the community exhibits were prepared for the physicians arriving that evening. Some communities had elaborate displays and as many as 10 or 12 representatives from a single community.

The physicians and their spouses arrived Friday afternoon and, after registration, attended a hospitality hour held in the area of the community exhibits. This provided 2 hours of intensive physician-community interaction on both Friday and Saturday evenings, and was one of the highlights of the conference.

The program on Saturday and Sunday organized by the physicians dealt with issues related to entry into practice in a non-urban setting. Speakers were either physicians or others actively involved in practice settings. They covered such subjects as social considerations, community resources and facilities, practice arrangements, government related problems, the economics of opening a practice, and meeting the high demand of this practice setting.

The most important outcome of the conference will be the number of physicians eventually placed with communities. It has become apparent over the last year, however, that there are other important outcomes. One community attended the conference and did not recruit a physician but was stimulated by the conference to use other conference-related resources to recruit for physicians last year. Physicians are also given a perspective on non-urban practice that dispels the stereotyped image of the over-worked and out-of-date physician and creates a more positive and accurate one of an up-to-date practice with a reasonable life style. Many communities and physicians, then, may not find an immediate answer to their questions, but may be stimulated to work more constructively by the potential demonstrated at the conference.

The second Pre-Practice and Physician Recruitment Conference was considered a great success by the MAG and the SICH. Several important improvements were made over last year's conference (*JMAG* 66:12, 1977). When responses to the evaluation questionnaires from both communities and physicians are received, plans will be finalized for the 1979 Conference to be held October 25-28 at Callaway Gardens.



Figure 1 — (L to R) Walter Disher, Jerry Hummell, and Dr. M. Julian Duttera, Jr., discuss issues related to practicing in a non-urban community.



Figure 2 — Conference attendees learn how to effectively utilize office personnel.

I've told this before . . .

(Editor's Note: When someone asks you for directions, you *may be the one who learns the way. Others wishing to contribute to this page are invited to send their stories to the* Journal, *938 Peachtree St. NE, Atlanta, Ga. 30309.)*

Eureka!

A FEW MONTHS AGO, some friends of ours named Joe and Mary Bremer joined Marguerite and me for dinner at a restaurant on Cheshire Bridge Road.

We purposely went a little early to avoid the crowd so we could eat leisurely and have time to play bridge afterward. The drinks were good; you could actually taste the bourbon. The food was well-prepared and reasonably priced, and they did not give you gigantic helpings like so many restaurants do. The service was par excellence. As we were leaving the Colonade, we noted that all the tables were filled. We were pleased with our astuteness in arriving early and looked forward to a pleasant evening of bridge.

I was in the lead going to the car when a nice-looking, young man came up to me.

"Pardon me, sir," he said, "Are you familiar with this area of Atlanta?"

"Reasonably so," I replied. "What can I do for you?"

"Could you tell me where Eureka Drive is?"

"Yes," I said, "but it may take me a minute." And I tapped my forehead. "Eureka Drive. Eureka Drive. It'll come to me in a minute. I remember seeing the sign because of its unusual name." Then I asked the others if they knew where Eureka Drive was. They didn't.

I was still looking off into space and in my mind going over the streets that I had traveled when he said, "Do you know where Lindberg crosses Cheshire Bridge Road up here at Hastings Nursery?"

"Oh, yes," I said.

"Well," said the nice man, "you turn to the left there and go about a mile. Then you come to another traffic light, a big intersection. That's Piedmont Road. Are you familiar with that?"

"Oh, yes! Quite."

"Well, you cross Piedmont Road. Go down the hill and under a railroad bridge. Follow me?" I nodded affirmatively. "Then," he said, "there is a road turning off to the left just after you go under the bridge, but you don't take that. Keep straight on . . ."

"And," I almost shouted, "the next street on the left is Eureka Drive!"

"You are absolutely correct!" said my new friend. He smiled and added, "Thank you so much."

As he walked briskly away, I replied with enthusiasm, "Thank you!"

J. G. McDaniel, M.D.
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MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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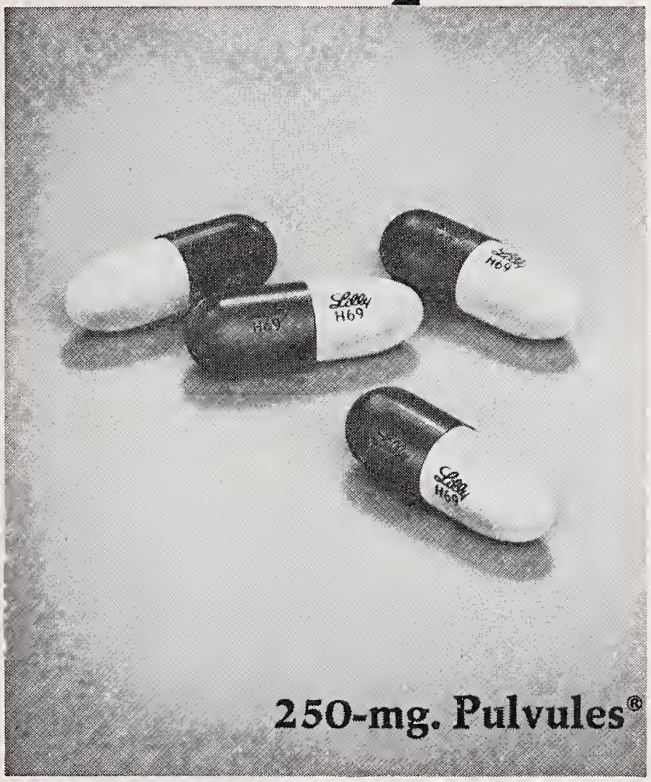
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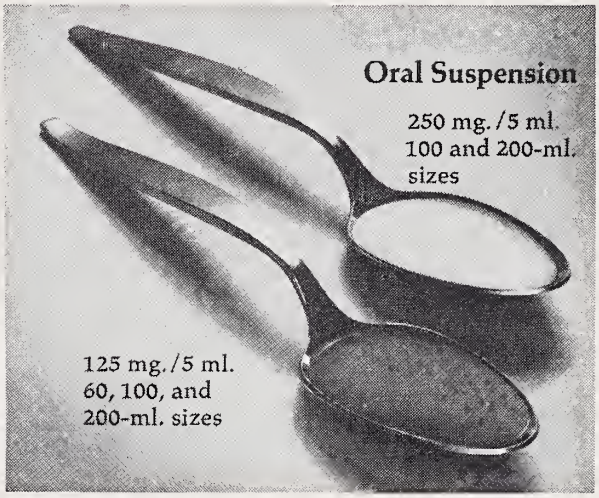
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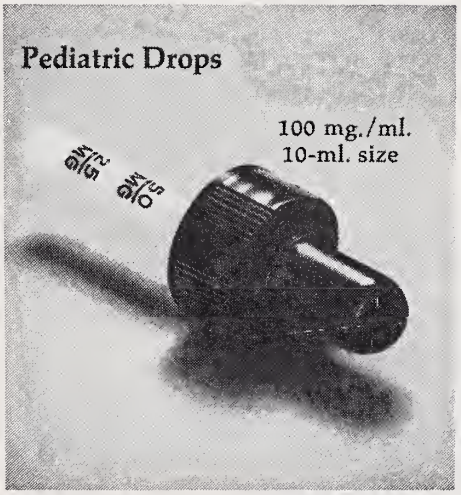
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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

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Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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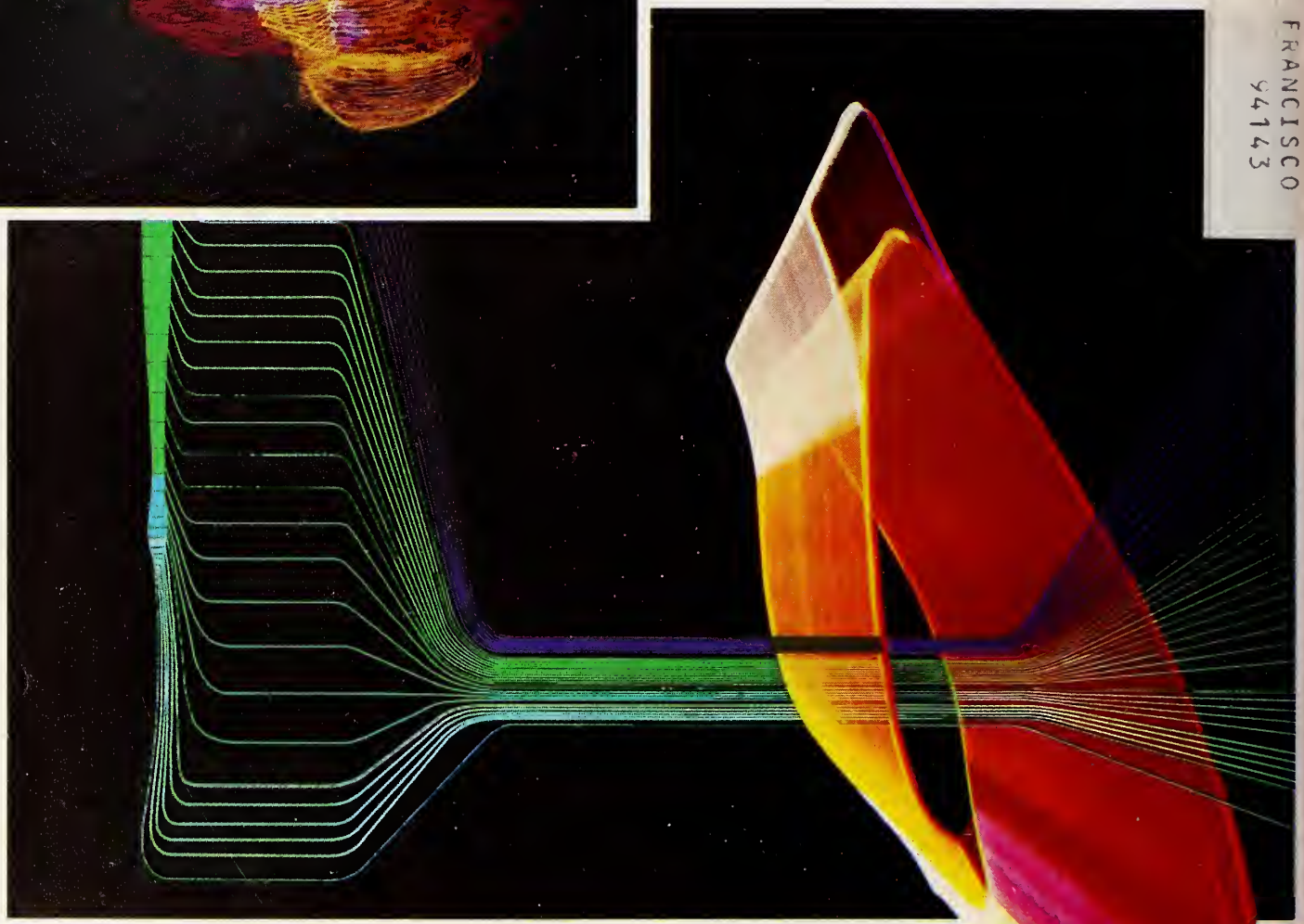
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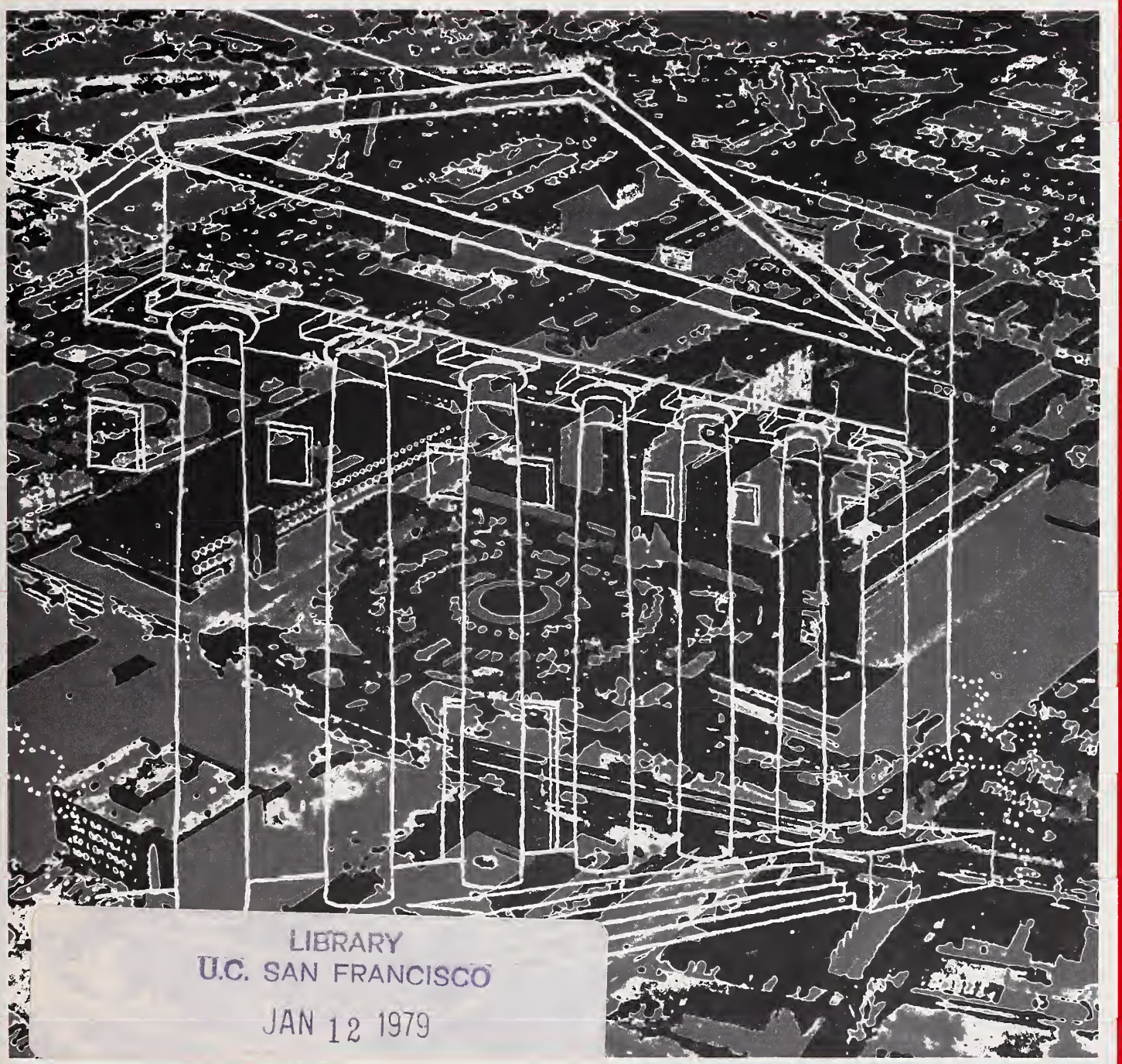
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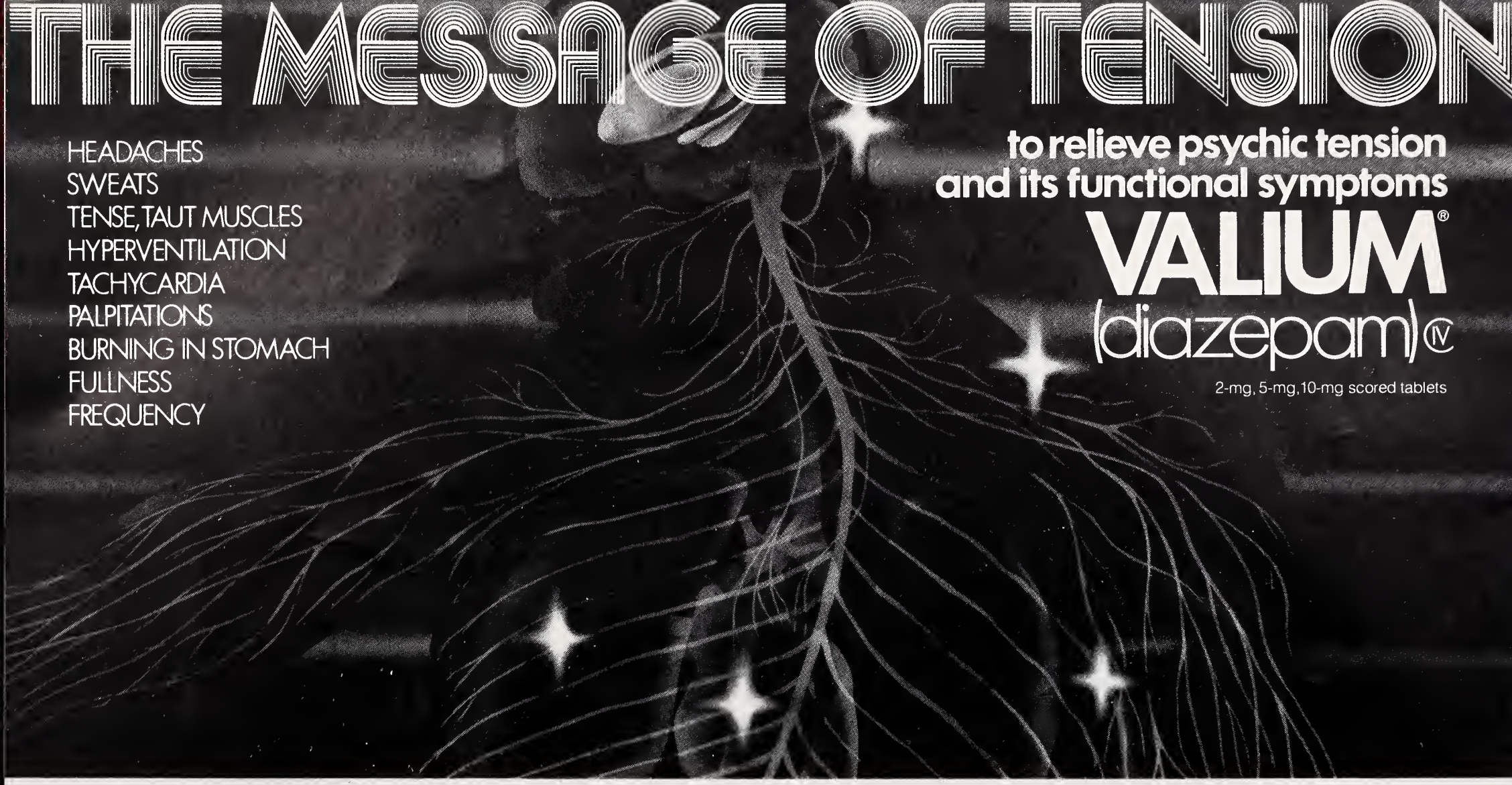
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, dizziness, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

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The cover design by John Stuart McKenzie commemorates the 150th year of the Medical College of Georgia. Read about its rich, interesting history on page 969.

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Magnet '78 Lauded

Dear Sir:

My congratulations to the MAG, the Communications Committee (Dr. Marvyn Cohen, Chairman), and to Ken Williams of MAG staff for an outstanding Magnet '78 Conference. The discussions were extremely timely, informative, and stimulating for the management of both professional and personal affairs. The panel from Practice Productivity, Inc. proved themselves to be exceptionally knowledgeable and capable in presenting their information.

As the announcements stated, "If you miss(ed) it, you deserve it."

Sincerely,
E. M. Molnar, M.D.
Columbus

John Byron (1692-1763)

Hymn for Christmas Day

Christians awake,
salute the happy morn,
Whereon the Saviour
of the World was born.

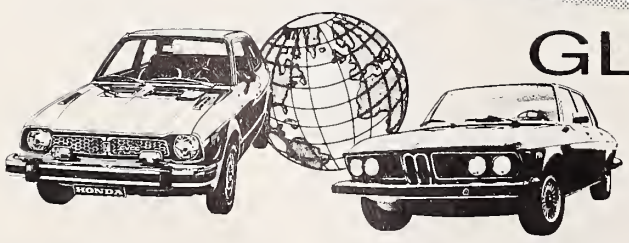
We at the *Journal* wish you a joyous holiday season. May it be the kind of hallelujah-like experience Dr. Mallory describes on page 990.

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MEDICAL MEETING CALENDAR

JANUARY

6-13 — *Caribbean Sea;* **CURRENT TOPICS IN PEDIATRICS;** Contact: Judson Hawk, M.D., Scottish Rite Hospital, 1001 Johnson Ferry Rd., Atlanta 30342. PH: 404/256-5252.

10 — *Greenville, NC;* **IMMUNOLOGICAL ASPECTS OF MALIGNANCY;** Category 1 Credit; Contact: F. M. Simmons Patterson, M.D., East Carolina University School of Medicine, Greenville, NC 27834.

17-19 — *Atlanta;* **VOCATIONAL IMPLICATIONS FOR THE CANCER DISABLED;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

18-20 — *New Orleans, LA;* **ALLIANCE FOR CONTINUING MEDICAL EDUCATION — 1979 ANNUAL CONFERENCE;** Contact: ACME, Miller Communications Inc., 322 Westport Ave., Norwalk, CT 06851.

18-20 — *Lake Buena Vista, FL;* **CARDIOVASCULAR SEMINAR FOR CRITICAL-CARE PERSONNEL;** Category 1 Credit; Contact: Bill Rockwood, University of Florida College of Medicine, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610.

19 — *Atlanta;* **NEONATAL SEMINAR;** Contact: Atlanta Lung Association Inc., 723 Piedmont Ave., N.E., Atlanta 30308. PH: 404/872-9653.

26-27 — *Winston-Salem, NC;* **CLINICAL UROLOGY;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27103.

29-February 3 — *Aspen, CO;* **THIRD ANNUAL EMORY CONFERENCE ON PAIN;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

30 — *Atlanta;* **TEAM BUILDING — A BETTER WAY TO SUPERVISE (WORKSHOP FOR OFFICE MANAGERS);** Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

31-February 1 — *Atlanta;* **STARTING YOUR PRACTICE (WORKSHOP FOR RESIDENTS);** Category 1 Credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

FEBRUARY

1-3 — *Chapel Hill, NC;* **WOMACK SURGICAL SOCIETY MEETING;** Contact: Noel McDevitt, M.D., Department of Surgery, UNC School of Medicine, Chapel Hill, NC 27514.

5-7 — *Atlanta;* **ANNUAL MATERNAL-FETAL POSTGRADUATE CONFERENCE;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/876-7535.

8-9 — *Augusta;* **CLINICAL PSYCHIATRY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

9-11 — *Lake Buena Vista, FL;* **GASTROENTEROLOGY FOR THE PRACTITIONER;** Contact: Bill Rockwood, University of Florida College of Medicine, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610.

14 — *Greenville, NC;* **PSYCHOPHARMACOLOGY UPDATE;** Category 1 Credit; Contact: F. M. Simmons Patterson, M.D., East Carolina University School of Medicine, Greenville, NC 27834.

16-20 — *Durham, NC;* **BASIC ELECTROENCEPHALOGRAPHY;** Contact: Malcolm H. Rourk, Jr., M.D., Director, CME, Duke University Medical Center, Durham, NC 27710.

17-25 — *Galapagos Islands;* **SIXTH ANNUAL PEDIATRIC DERMATOLOGY SEMINAR;** Contact: Guinter Kahn, M.D., 16800 N.W. Second Ave., North Miami Beach, FL 33169.

19-23 — *Durham, NC;* **MICROVASCULAR SURGERY WORKSHOP;** Contact: Malcolm H. Rourk, Jr., M.D., Director, CME, Duke University Medical Center, Durham, NC 27710.

22-23 — *Lake Buena Vista, FL;* **MANAGEMENT OF THE TINY BABY — 1979;** Contact: Keith S. Kanarek, M.D., 1416 South Orange Ave., Orlando, FL 32806.

MARCH

1-2 — *Atlanta;* **RECENT ADVANCES IN REHABILITATION OF THE RENAL DISEASE PATIENT;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

1-3 — *Gainesville, FL;* **SIXTH ANNUAL TOPICS IN UROLOGY;** Category 1 Credit; Contact: Bill Rockwood, University of Florida College of Medicine, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610.

1-3 — *Orlando, FL;* **GYNECOLOGIC ENDOCRINOLOGY AND INFERTILITY;** Contact: Bernard Cantor, M.D., Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610. PH: 904/392-3143.

3-4 — *Chapel Hill, NC;* **ANESTHESIOLOGY;** Contact: David Brown, M.D., Department of Anesthesiology; UNC School of Medicine, Chapel Hill, NC 27514.

3-10 — *Snowmass, CO;* **FOURTH ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 Credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

5-8 — *Atlanta;* **18TH NATIONAL CONFERENCE ON THE DETECTION AND TREATMENT OF BREAST CANCER;** Category 1 Credit; Contact: American College of Radiology, 6900 Wisconsin Ave., Chevy Chase, MD 20015. 301/654-6900.

5-9 — *Louisville, KY;* **PRACTICAL MICROSURGERY — A SYMPOSIUM AND WORKSHOP;** Category 1 Credit; Contact: Gerald D. Swim, University of Louisville School of Medicine, Office of Continuing Education, Health Sciences Center, P.O. Box 35260, Louisville, KY 40232.

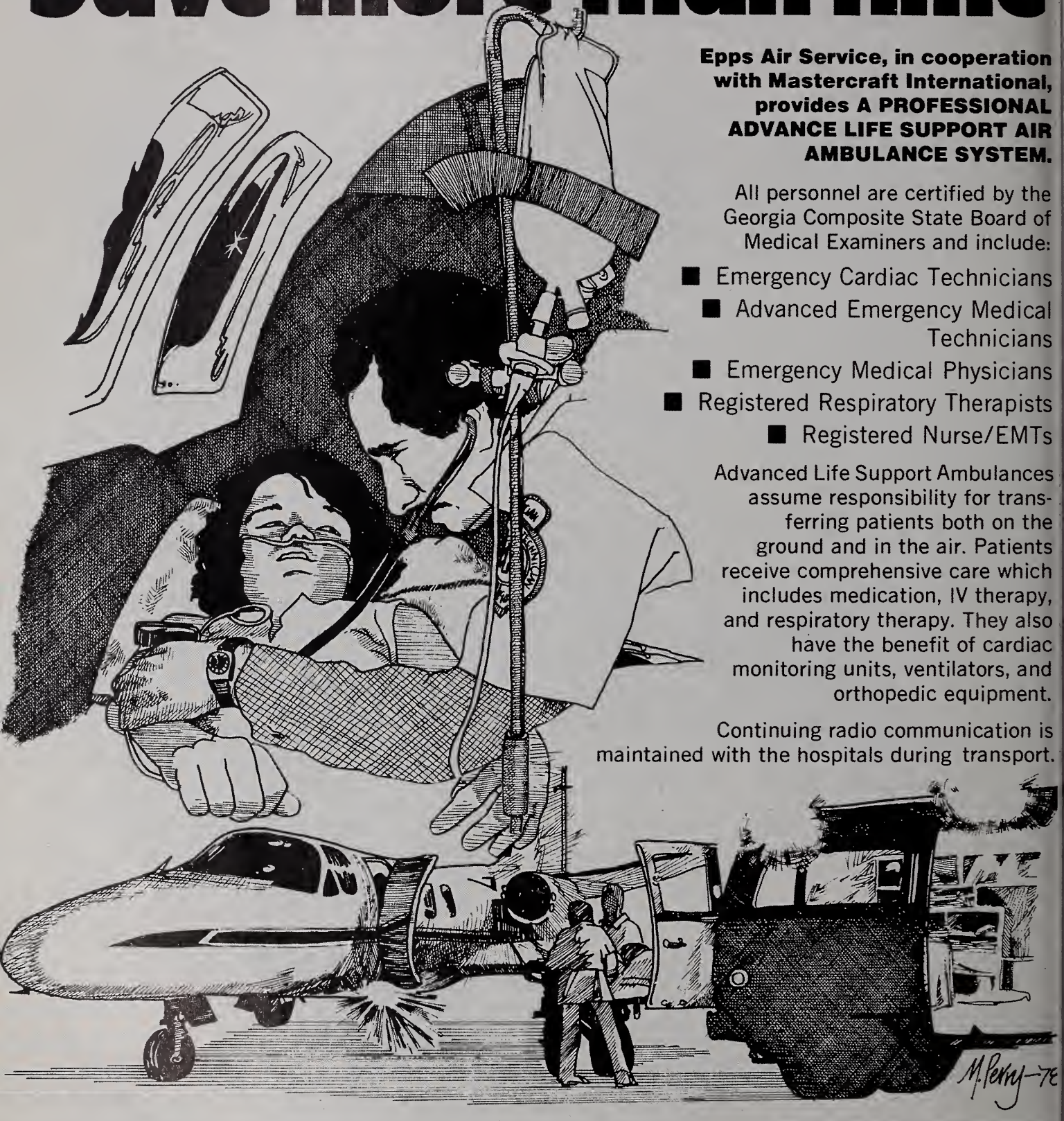
6-9 — *Tamarron Ski Resort, CO;* **EMERGENCY MEDICINE;** Category 1 Credit; Contact: Division of Continuing Education, Medical College of Georgia; Augusta 30901. PH: 404/828-3967.

7-10 — *Chapel Hill, NC;* **INTERNAL MEDICINE;** Contact: William Wood, M.D., Office of Continuing Education, 236 MacNider Building 202-H, UNC School of Medicine, Chapel Hill, NC 27514.

8-9 — *Winston-Salem, NC;* **TWO-DAY REAL TIME COURSES FOR OBSTETRICIANS;** Category 1 Credit; Contact: James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

11-14 — *Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Winnie Hopkins, 875 West Peachtree St., N.E., Atlanta 30309. PH: 404/881-6128.

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Medical College of Georgia Celebrates Its 150th Year

WILLIAM H. MORETZ, M.D., and DOUGLAS C. VINSON, *Augusta**

The Medical College of Georgia (MCG) in Augusta celebrates its 150th year this month and heralds as the proud product of a long and distinguished past. A small School of Medicine for its first 122 years, it is today a relatively large university of health sciences, with schools in medicine, graduate studies, nursing, allied health sciences, and dentistry. Its 80-acre campus in downtown Augusta (Figure 8) has over $100 million in physical facilities, and growth continues with some $35 million in land acquisition, renovations, and new structures projected in the near future. Just as impressive as the physical facilities is the potential of the 604 full-time faculty, the commitment of its 2,300 students, and the skill of its 4,500 employees. This brings to mind the words on the tombstone of one of the founders of the college, Dr. Milton Antony (Figure 1), "He Built a Lasting Monument."

Antony and a small group of Augusta physicians laid the cornerstones for a lasting monument to man's concern for man. To move from seven students and three faculty members in two rooms in the back of an old city hospital in 1828 to a $90 million-budgeted university in 1978 is a testimony to the vision and dedication of those associated with the college over the last 150 years.

Antony was among several Augusta physicians who organized a society in 1822 and applied to the General Assembly for a charter granted in November of 1822 establishing the Medical Society of Augusta. There can be no doubt that the primary objective of this group was the establishment of an institution for education of physicians. In 1825 the State Board of Medical Examiners was established, also through the efforts of this dynamic, self-educated physician.

By 1826, Dr. Antony and a younger colleague and pupil, Joseph Adams Eve, had started instruction at the City Hospital which was built in 1818 and housed the nascent medical college until 1835.

Dr. Antony and other Medical Society members, with the support of the Augusta City Council, applied to the state for a charter to establish a medical college. It was signed by an Augustan, John Forsyth, who was then governor and who later became a member of Andrew Jackson's cabinet.

The Medical Academy of Georgia, the first school of medicine in Georgia, was off to a modest start with authority to grant the Bachelor of Medicine degree. Training was in two renovated rooms equipped with $457 of faculty-donated money. The academy trustees sought authorization to offer a second year of training in preparation for an M.D. degree. This was granted in 1829, and the name was changed to the Medical Institute of Georgia. In April of 1833, the Institute publicly granted its first four M.D. degrees. Encouraged by this progress, the school's name was changed in 1833 to the Medical College of Georgia. It was during this era that two men joined the faculty who, along with Dr. Louis D. Ford, professor of materia medica, would spend a half century with the school. They were Drs. Joseph Adams Eve and Louis A. Dugas.

A new era began for the college in January of 1835 with the completion of a new building at a cost of $15,000. This building, now called the Old Medical College Building and the home of the Augusta Council of Garden Clubs, is a magnificent example of Greek revival, doric-style architecture.

Growth of the school was rapid and substantial, marred only by the death from yellow fever of Dr. Antony in 1839 and the moving of the renowned professor of surgery, Dr. Paul F. Eve to Nashville in 1850. An important factor in this rapid development was a project in which the faculty raised $6,000 and sent Dr. Dugas to Europe to buy "anatomical museum, chemical apparatus, and other items for use at the college." He returned with an excellent collection which became the nucleus of the medical library.

* Dr. Moretz is the President of MCG, and Mr. Vinson is in public relations at MCG. Their address is Administration Building, MCG, Augusta, GA 30901.

Growth and development was brought to a halt in 1861 with the outbreak of the Civil War. No formal classes were held for the next 4 years. However, 47 students registered in November 1865, and a class of nine students received degrees in February 1866. The school owed much in these years to George Washington Raines. A graduate of West Point, Raines came to the South at the time of Civil War to manufacture gunpowder for the Confederate States. Although he was not a physician, he became Dean of the Medical College and did much to bring the school back to its high pre-war standing.

One major step in that direction was joining the Medical College to the University of Georgia. A committee was appointed in 1867 to confer with the trustees of the University of Georgia about a merger. In 1873, the Medical College of Georgia became the Medical Department of the University of Georgia. This more modest title was compensated for by the prestige of a university connection.

During the 1870's, the college sought, as it had several decades earlier, to raise educational standards by extending the course of lectures from a 4 to a 5-month lecture term in 1878-79. There was at the time a rising national distress concerning the inadequacies of medical education. (At the Harvard Medical School of the time, President Charles Eliot urged that medical students be required to pass a written examination before graduating. Professor Henry Bigelow protested that this was impossible because, "more than half of them can barely write. Of course they can't pass written examinations.") Nevertheless, the College continued to do what it could in the cause of higher standards. It sent representatives to Philadelphia in June 1876 to participate in the founding of the Association of American Medical Colleges. The prime purpose of this organization was to raise the medical education standards in the United States.

With 15 doctors present on August 31, 1891, the Alumni Association of the Medical Department of the University of Georgia was organized. Today, it has more than 3,000 members living throughout the United States and many parts of the world.

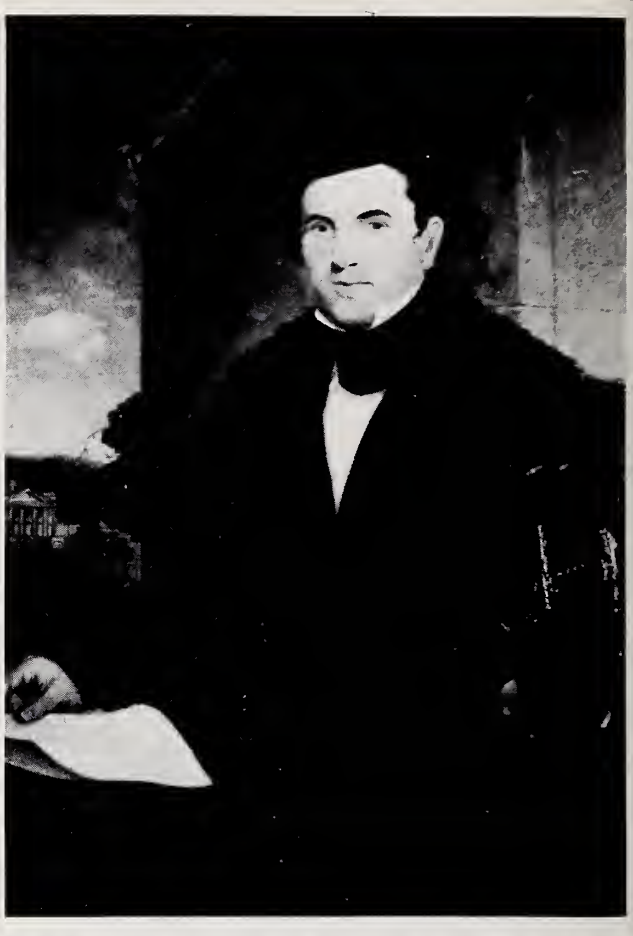


Figure 1 — Dr. Milton Antony, one of the founders of the Medical College. "He Built a Lasting Monument."

Dean Raines's efforts to raise standards were rewarded in 1893 when the 5-month lecture term was extended to 6 months and 3 years of work were required for graduation. This time the new standard was maintained, although many other medical colleges retained a 2-year requirement. The goal for excellence was established in the laboratory, as well as the classroom. Figures 2 and 3 show what it was like in a medical school laboratory in the 1890's.

After Raines's retirement at the end of the 19th

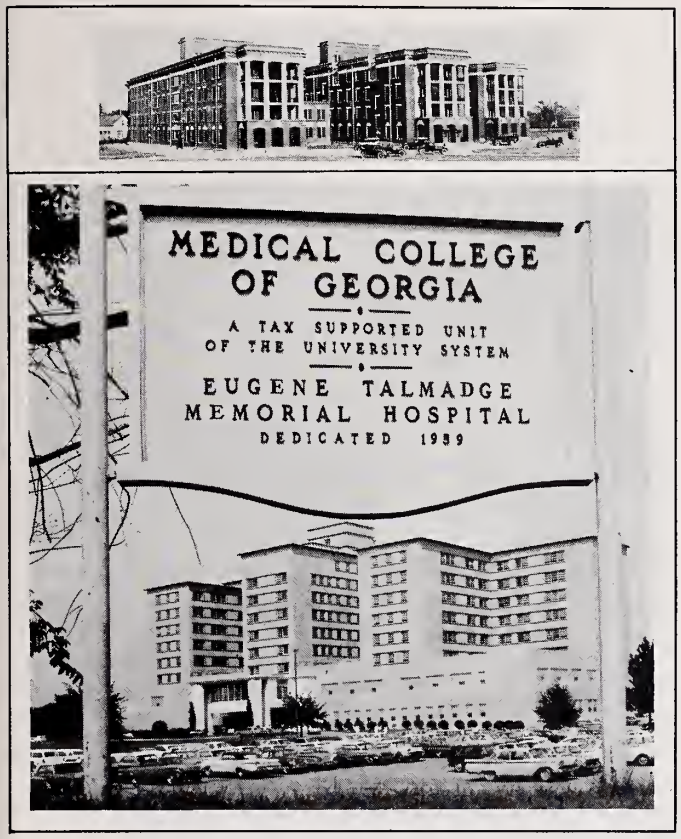


Figure 2 — Students learn the rudiments of human anatomy in this late-19th century dissecting room.



Figure 3 — Laboratory work is an integral part of medical education. Here, late-19th century students study essentials in pathology.

Figure 4 (TOP RIGHT) — The move to the Newton Building at the beginning of the 20th century heralded a new era in the history of the Medical College. Figure 5 (TOP LEFT) — The University Hospital as it appeared shortly after its completion in 1915. This was the primary teaching hospital of MCG until Talmadge Hospital (Figure 6 — BOTTOM LEFT) was opened in 1956. Figure 7 (BOTTOM RIGHT) — The latest addition to Talmadge Hospital, the Virgil P. Sydenstricker Wing, was opened in 1978.



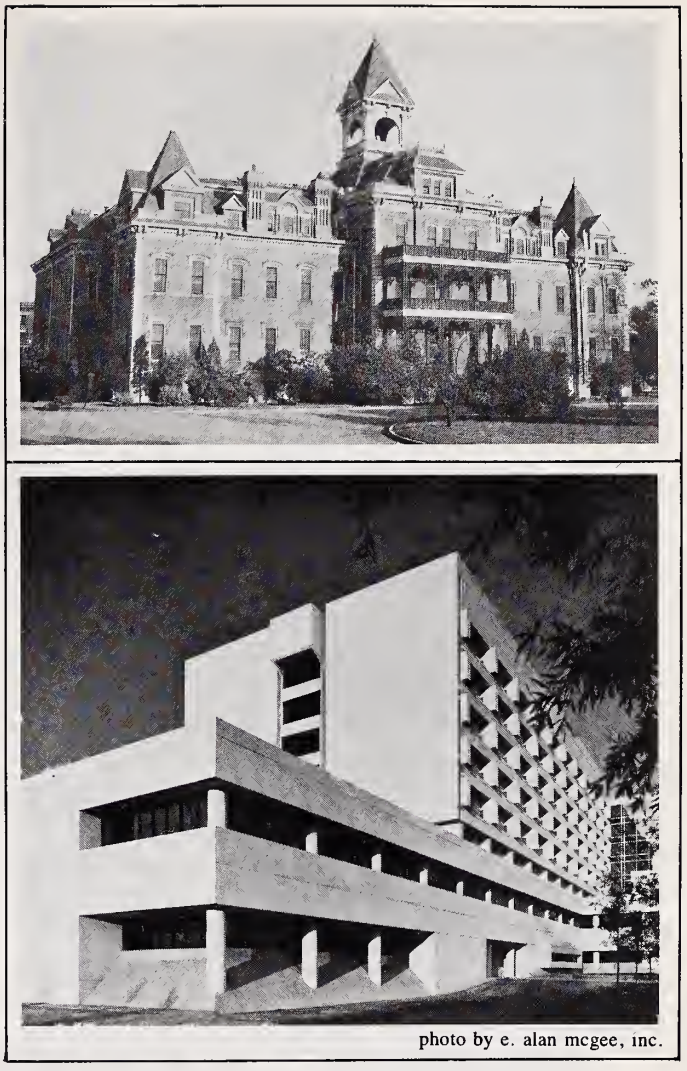


photo by e. alan mcgee, inc.

century, little progress was made in the ensuing decade. Medical education over the entire nation sank to a low level during the first decade of this century. It became so bad that a major investigation was made by Abraham Flexner; the results were published in 1910 under the title *Medical Education in the United States and Canada*. This report was very critical but so well-documented that in the next few years almost half of the medical schools in the nation were forced to close.

Regarding the medical school in Georgia, Flexner reported that entrance requirements for the 99 students were very low, there were only 19 professors, and the budget of $6,835 was generated entirely by fees. He found the equipment inadequate and the connection with the University of Georgia of no real consequence. Calling the "Augusta situation hopeless," he recommended that the University "snap the slender thread" that bound it to the medical department. The result would be the end of the medical school.

The Medical Department of the University of Georgia took these severe criticisms seriously but dismissed Flexner's recommendation to give up the struggle. Instead, sweeping reforms were made. The old building on Telfair Street was abandoned and newly renovated quarters in the Newton Building were occupied (Figure 4). Construction was begun on University Hospital (Figure 5), and the faculty was reorganized. Full-time clinical teachers were employed. The challenge to be worthy of survival was met, and a new era of growth began that lasted for almost 2 decades.

The Board of Regents, which governs the University System of Georgia, was established January 1, 1932. With this step, control over the Medical Department passed to the University, and the medical school's Board of Trustees was abolished.

Dr. G. Lombard Kelly became Dean in 1931 and proved to be an able leader. He found strong support from a group of associates who were men of vision tempered with an appreciation of the practical problems of medical education. Despite the national depression and World War II, progress was made in building new facilities and adding new faculty members.

The modern period of the Medical College began in 1949. Major changes were initiated then that had far-reaching effects on the institution. A teaching hospital was authorized in 1949. The next year, the medical college was separated from the University of Georgia and recognized as an independent unit in the

University System under the direction of the Board of Regents. Dean Kelly became the school's first president and served until his retirement in 1953. Also, the name Medical College of Georgia, abandoned in 1873, was restored. Between 1950 and 1956, over $13 million was spent on the construction of the new teaching hospital, new science facilities, and related buildings. In 1956, the Talmadge Memorial Hospital was opened (Figure 7). It was the college's first wholly owned and operated teaching hospital.

Dr. Edgar R. Pund, who became president in 1953, continued to consolidate and expand the progress begun in that decade. The clinical, part-time faculty was changed to full-time status. Under his administration, the MCG Foundation, Inc. was established. Endowment money from this foundation is used for faculty recruitment, financial aid to students, and other vital programs at the college.

Dr. Harry B. O'Rear, now vice chancellor of health for the University System of Georgia, became president in 1958. During his administration, the research wing of the hospital was completed. Construction of the library, student center, research and education building, student housing and several other buildings were initiated and completed. These additions helped to bring about the transformation of the medical school into a health sciences university.

The School of Nursing was strengthened, expanded, and moved from Athens to Augusta in 1956 and has continued to experience steady growth.

The School of Graduate Studies began in 1962 and offers advanced degrees in the basic sciences. The primary purpose of this school is to train teachers for premedical courses at the undergraduate level and basic science (i.e., biology, anatomy, chemistry, physics, etc.) and teachers for medical and other health-professional students. This school also develops the interest and skills of those who are to become researchers in the future.

When it was established in 1968, the School of Allied Health Sciences brought under its wing four educational programs in medical technology, and medical illustration. In response to the growing need for a variety of allied health workers in Georgia and the nation, other educational programs have been added. These include dental hygiene, nuclear medicine technology, occupational therapy, physician's assistant training, physical therapy, and respiratory therapy.

The School of Dentistry admitted its first students in 1969 and has gained national recognition for its programs and research conducted by its faculty.

William H. Moretz, M.D. (Figure 10) became president in 1972, and the expansion program of the post-war years accelerated. The $44 million budget

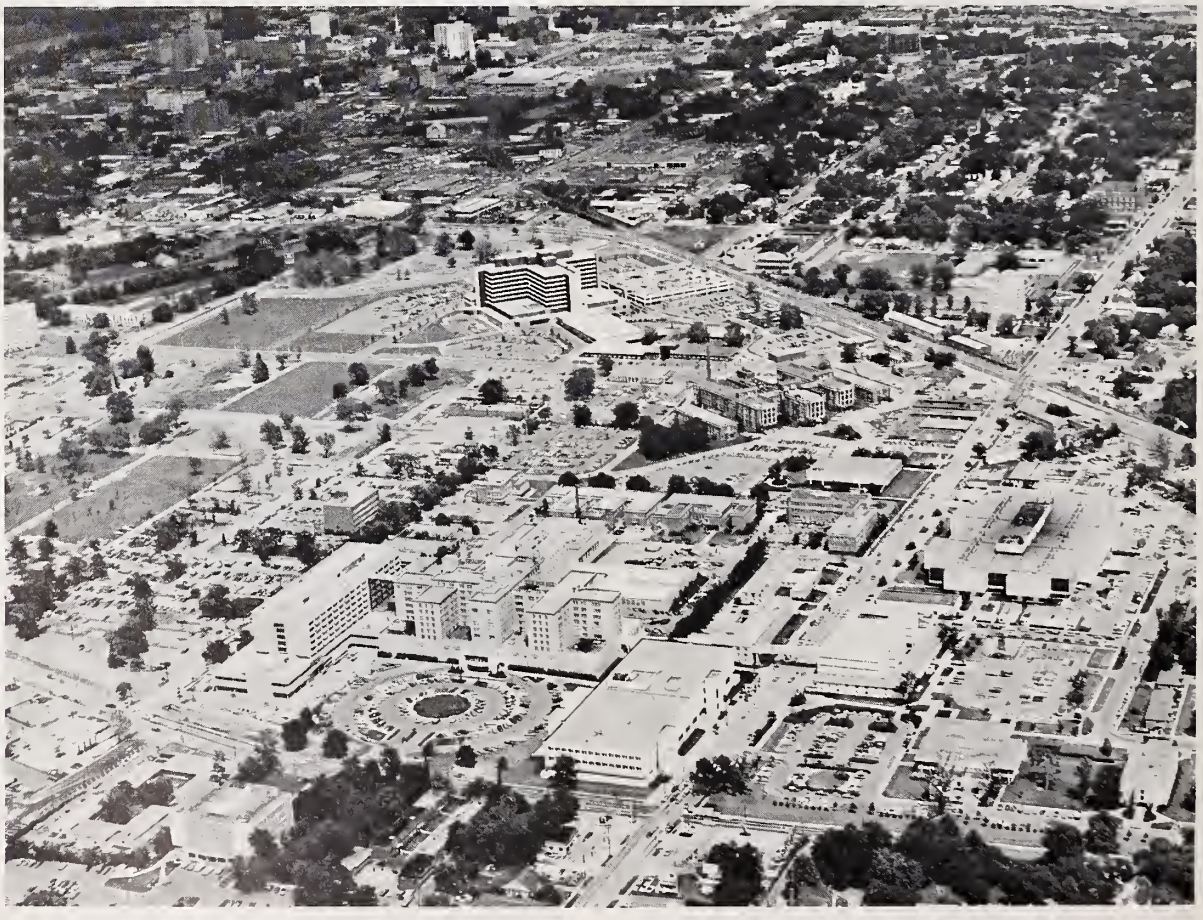


Figure 8 — A bird's eye view of the Medical College of Georgia, situated in downtown Augusta.

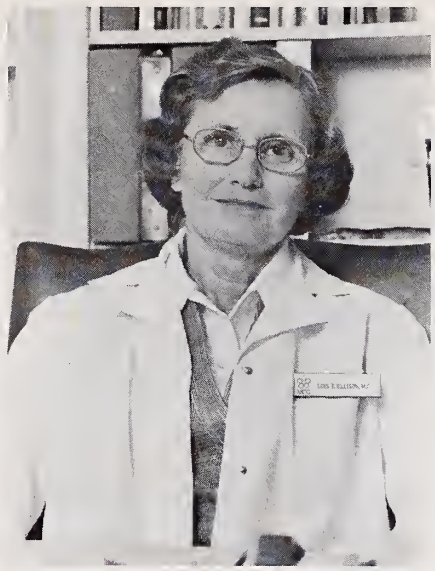
Figure 9 (TOP LEFT) — Dr. Lois T. Ellison, Provost of the Medical College.

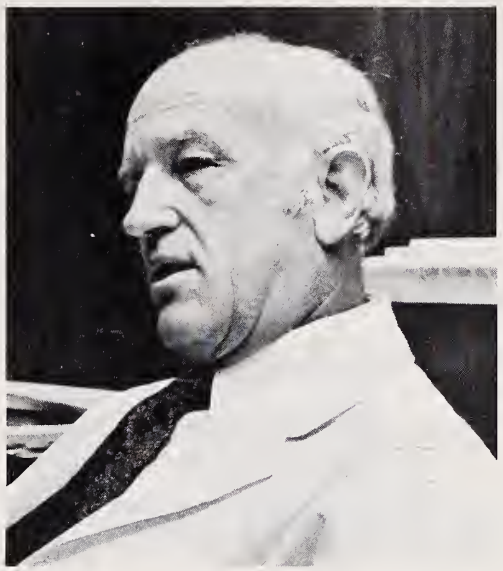
Figure 10 (TOP RIGHT) — The Medical College's fourth president, William H. Moretz, M.D.

Figure 11 (BOTTOM LEFT) — Dr. Raymond Ahlquist, recent recipient of the Lasker Award.

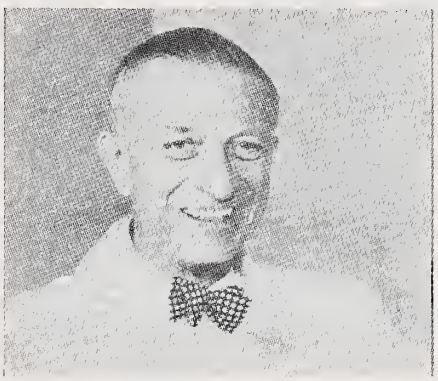
Figure 12 (MIDDLE) — The late Dr. Virgil P. Sydenstricker, renowned former chairman of the Department of Medicine.

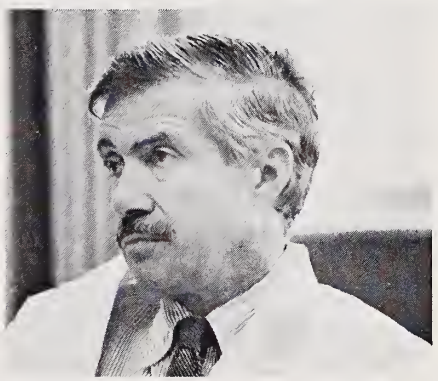
Figure 13 (BOTTOM RIGHT) — Dr. Fairfield Goodale, is Dean of the School of Medicine.











of 1971-1972 eventually more than doubled to the $90 million budget set for 1978-1979. Enrollment for the same period has gone from 1,332 to 2,300.

Physical expansion has continued. The Virgil P. Sydenstricker Wing (Figure 7) was added to the Talmadge Hospital in 1976. The Hamilton Wing was added to the Sanders Research and Education Building. The School of Dentistry was enlarged, and extensive renovations in the teaching hospital and other buildings has begun. An extensive addition to the library is underway. Construction of a radiation therapy center will begin this year. Additional property for future expansion has already been purchased.

Dr. Fairfield Goodale (Figure 13) became Dean of the School of Medicine in 1976. He also acts as the Medical Director of the hospital and clinics. In her job as Provost of the College, Lois T. Ellison, M.D., (Figure 9) works with the deans of the five schools and helps coordinate their curriculum.

The recent history of the MCG has produced numerous individuals whose contributions to medicine are extremely significant. The late Dr. Virgil P. Sydenstricker (Figure 12) is credited with discovering evidence that led to the effective treatment of pellagra. Dr. W. F. Hamilton fashioned instruments and techniques that are acknowledged as vital forerunners of present-day open-heart surgery.

The College also has many outstanding faculty members on its present staff, including the current holders of Regents' professorship, Virendra B. Mahesh, Ph.D., Chairman of the Department of Endocrinology, Titus H. J. Huisman, Ph.D., Chairman of Cell and Molecular Biology, and Keith Green, Ph.D., Department of Ophthalmology. Four faculty members hold Charbonnier professorships. They are Sam A. Singal, Ph.D., Dean of the School of Graduate Studies, Robert G. Ellison, M.D., in thoracic surgery, William B. Strong, M.D., in pediatric cardiology, and Raymond P. Ahlquist, Ph.D., in pharmacology. Dr. Ahlquist (Figure 11) is the recipient of the Lasker Award, one of the highest awards given to researchers, for his concept of receptor "receiving stations" for hormonal messages in the cardiovascular system.

In human terms, a century and a half is a long time. Our nation is only 52 years older. The going has not been easy. The Medical College nevertheless has survived its critics and justified the faith of its friends. Secure in a proud tradition, it looks forward with confidence to a future of greater service to the state and the nation.

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Failure or decompensation of pulmonary ventilation or gas transport can occur frequently in the setting of trauma, sepsis, and major surgical intervention.

Respiratory Failure in The Surgical Patient

JOHN T. BONNER, M.D., *Atlanta**

RESPIRATORY FAILURE can be a major contributing factor to the mortality of the surgical patient. Respiration in this sense includes not only ventilation but also adequate organ perfusion, gas transport to and from tissues, and oxygenation at the cellular level.

At Grady Memorial Hospital in Atlanta in 1977, the overall successful weaning (ventilator withdrawal) rate was 72% for all patients who received some form of mechanical ventilatory support as part of their respiratory care. This represents an improvement of 9% over that in 1975.

In the Surgical Intensive Care Unit (SICU) at Grady, over 219 patients received mechanical ventilatory support in 1977. This group of patients had respiratory failure associated with a surgical illness. The successful weaning rate of patients in this group was 86% in 1977, compared to 79% in 1975. (These figures are based on a sampling of 6 months of each year.) A major factor in the improved weaning rate is better respiratory care provided by trained personnel assigned to the unit.

There has been much enthusiasm generated among those responsible for respiratory care about high-level positive end-expiratory pressure (PEEP) and left-sided cardiac monitoring with the Swan-Ganz catheter. Our approach toward good respiratory care has included these modalities of therapy and monitoring, as well as basic principles of applied physiology and pathology. We believe that the decrease in mortality, successful ventilator withdrawal, and improved patient care have been mostly due to applications of accepted principles of good respiratory care.[1, 2] Some of these are inherently simple, yet sometimes difficult to implement. They include the following:

1. Handwashing before patient contact. Isolation by room partition and nursing care of those with purulent sputum and draining wounds.
2. Daily chest films and correlation with physical chest examination.
3. Daily sputum cultures.
4. Gram stain of sputum if changes occur in patient's condition.
5. Appropriate care of artificial airways (endotracheal tube or tracheostomy) by house staff in surgery and anesthesiology. "Soft" cuff use and attention to tube position and cuff inflation pressure are included in the care of artificial airways.
6. Adequate hematocrit for oxygen and carbon dioxide transport.

Inadequate nutrition depresses ventilatory drive and makes weaning from the ventilator difficult.

7. Early attention to adequate nutrition. (Recent data indicate that inadequate nutrition depresses ventilatory drive and makes weaning from the ventilator difficult.)[3] Nutritional support by enteral or parenteral routes is indicated for the patient expected to be in respiratory failure for several days.
8. Low-to-moderate PEEP for most patients with a widened alveolar to arterial PO_2 difference in the setting of low-lung-volume syndrome. No patient with respiratory failure is allowed to breathe spontaneously against ambient pressure for more than a few hours. The old "T-tube" trials, in which assisted ventilation is alternated with periods of totally spontaneous breathing, are discouraged.
9. Daily weighing of the patient and measurement of serum sodium.
10. Daily measurement of vital capacity, compliance on the ventilator, and blood gas determinations.

* Dr. Bonner is an assistant professor in the Department of Anesthesiology and Surgery at Emory University School of Medicine, 80 Butler St., SE, Atlanta, Georgia 30303.

11. Measurement of arterial-to-venous (A-V) oxygen content differences in patients who have central venous lines. Such data indicate the adequacy of oxygen transport in relation to tissue extraction by the Fick principle: Cardiac output equals total body oxygen consumption divided by A-V oxygen content difference.
12. Daily shunt calculation. The shunt is calculated while the patient is breathing the desired percent of oxygen, *not* pure oxygen. (Breathing pure oxygen has been shown to cause absorption atelectasis and change ventilation to perfusion relationships.[4])
13. High-level (greater than 20 cm of water) PEEP is occasionally indicated for patients with calculated pulmonary shunts over 20% who have very stiff lungs that are not improving. Left-sided (Swan-Ganz) cardiovascular monitoring is usually begun in such patients in order to more effectively manipulate volume and dosage of cardiovascular drugs.
14. Intermittent mandatory ventilation is employed in virtually all paticnts receiving ventilatory support. Withdrawal from the support is simple, and many disadvantages of assisted or controlled ventilation are avoided. These disadvantages include alkalosis, barotrauma, and discoordinate ventilation.

The round-the-clock activities of trained respiratory therapists, technicians, and masters-level physicians' assistants have made the implementation of efficient respiratory care possible. Critical-care nurses and respiratory-therapy personnel have learned to work as an effective patient-care team and complement each other in the intensive care unit. The cooperation and understanding of these individuals are necessary if survival rates are to continue to improve. They effectively implement bedside care within the limits determined by the attending physicians, and they are the key to good results obtained from therapy of respiratory failure.

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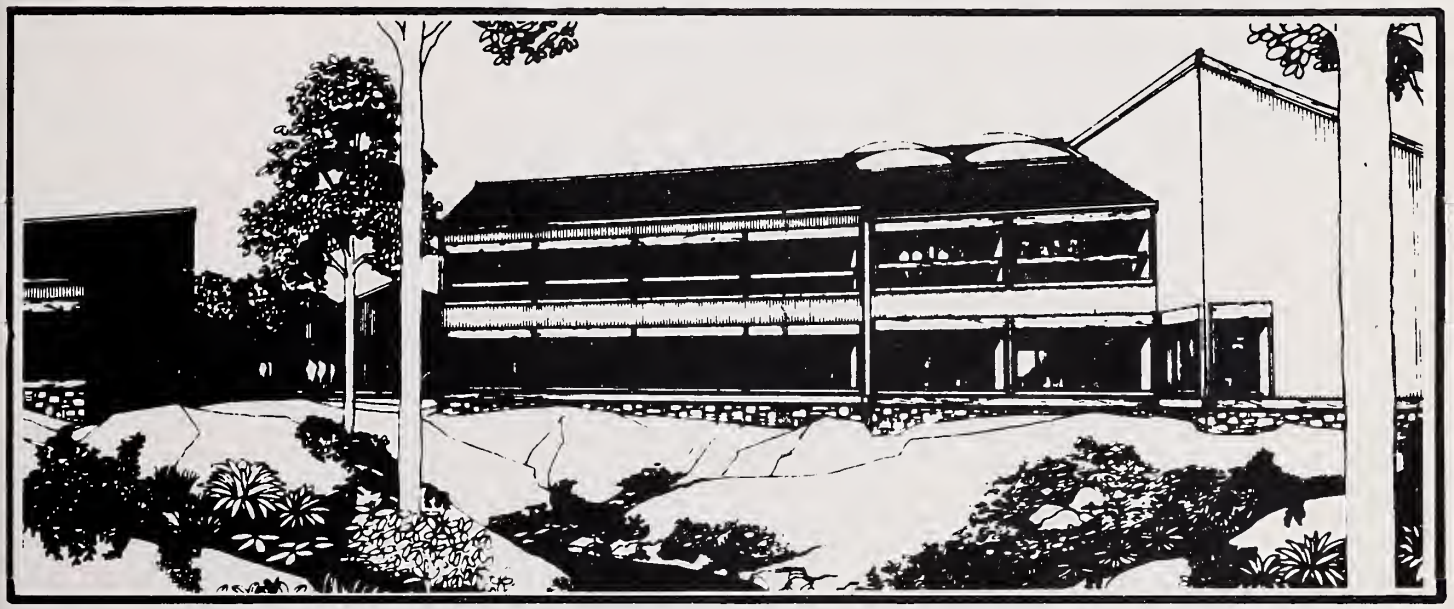
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A heart-warming vignette that points up the personal touch in the practice of medicine.

Mr. G. — A Vignette

JOHN STONE, M.D., Atlanta*

What medicine comes down to — or up to — is people. And, finally, to a person who happens to be sick. At the other end of every technological advance, behind the computer's laboratory report, among the surrealistic patterns of the CAT scan, there is a person. The following vignette seems to me especially appropriate for the practice of medicine at Christmas time. For Christmas is also about people. I first knew Mr. G. when I was a Fellow in Cardiology at Grady Memorial Hospital/Emory University School of Medicine. As the story says, it was in 1967.

* * *

Mr. G.

No one should die in 1967 of a dead battery. So when I first saw Mr. G. with his heart rate of 30 a minute, I knew he needed a pacemaker: a new battery for his heart which missed the 70 beats a minute it was supposed to get. Otherwise, he was in good 64-year-old shape.

It did take some talking, though. The Bible says don't mess around with things too much; His eye is on the sparrow; the hairs on your head are numbered. That sort of thing. So I told him the truth, but as Emily Dickinson said to do, I told it "slant," only mentioning the dire consequences of *not* having a pacemaker, such as stroke, heart attack, falling out spells, broken hip or head.

And I told him sometimes the doctor has to help God.

He consented, after a couple of perilous nights at a rate of 30, to a temporary pacemaker — a wire threaded along an arm vein into the heart and pulsed by an external battery. He immediately felt better. Two weeks later he allowed us to put in a permanent pacemaker, this time the battery surgically placed in a small pouch in the abdomen. And Mr. G. felt great.

Eight years passed, and several batteries were changed using a simple surgical procedure done every 2 or 3 years under local anesthesia. He continued to feel fine, the clock under his belt blipping its 70 times a minute with immaculate regularity. Periodically, he dropped by the office for my reassuring check of his pulse at the wrist. Most of the time he checked it himself, twice a day, at home, testing its rate by holding a radio over his abdomen and listening for the sharp merciful static the battery makes. At first he was almost as afraid of the battery as he was dependent on it. But he got used to it with time.

Two years ago, he came to the office in mid-dead-winter with an outsized coat and no sweater, but smiling. I told him he needed a sweater and I'd bring him one of mine from home, a wooly warm one my mother had given me that didn't match a thing I'd gotten any Christmas. He was to come back for it in a few days.

He didn't come back.

Outside the office window the seasons passed, several of them, and no Mr. G. By the next winter I'd given up on him. The body is heir to many problems besides battery problems. I wrote a poem about him. I took the sweater home.

Yesterday, 10 years after his first battery, he smiled in through the doorway to the office. I was astonished, and my face showed it. "I thought you'd — *moved,* Mr. G."

"You thought I was dead," he said. "You thought I was dead."

* * *

I still see Mr. G. from time to time around the hospital. He still stops by for a check of his pulse. And he still smiles, in a knowing way, when I tell him he's fine. I have the feeling that he knows at least as much about me as I do about him. But then many of our patients do. It is with a special pleasure that at this time of year I wish him a Merry Christmas — and, of course, regular as a clock, many more New and Happy Years.

John Stone, M.D.
80 Butler Street
Atlanta, GA 30303

*Dr. Stone is Professor of Medicine (Cardiology) and Director of the Emergency Medicine Residency at Grady Memorial Hospital/Emory University School of Medicine. This vignette will appear in his second book of poetry, *In All This Rain,* to be printed in 1979 by the Louisiana State University Press. His address is 80 Butler St., Atlanta, GA 30303.

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The author discusses experiences with 47 babies born to 37 women after jejuno-ileostomy. The results suggest that patients who have had jejuno-ileostomy may be optimistically advised to become pregnant.

Conception, Pregnancy, and Delivery After Jejuno-ileostomy for Obesity

CHARLES E. WILLS JR., M.D., *Washington

PUBLISHED INFORMATION on obstetric delivery after jejuno-ileostomy for obesity is scarce.[1-8] This may be partially due to the obstetrician's lack of interest in bypass surgery and to the surgeon's lack of interest in obstetrics. This paper deals with obstetric experiences obtained in the follow-up of 770 cases of surgical bypass for obesity between November 1963 and January 1978.

Methods and Materials

Information was compiled by reviewing the office and hospital records of 13 babies delivered by the author. Questionnaires were sent to the various physicians who delivered 34 other babies. All but one of the jejuno-ileostomies were performed by the author. The total number of babies born was 47; however, information was obtained on only 45. This information was not always complete, which accounts for the apparent discrepancies in the numbers recorded.

Results

The patients' weights before the jejuno-ileostomy varied from 80 kilograms (kg.) (176 lbs.) to 161.8 kg. (356 lbs.). The average weight before the jejuno-ileostomy was 112 kg. (246.5 lbs.). The weights after the jejuno-ileostomy ranged from 52.7 kg. (116 lbs.) to 114.5 kg. (252 lbs.), with an average of 75.6 kg. (166.4 lbs.). Average weight loss was 36.3 kg. (80 lbs.).

The time between jejuno-ileostomy surgery and delivery ranged from 10 months to 9 years and 4 months, with an average of 2 years and 8 months.

The patients' ages at the time of bypass surgery ranged from 13 to 33 years, with an average of 24 years. Thirty women had their first baby after the surgery; 17 had had previous pregnancies.

Information regarding sex was available for 28 of the babies: 15 were male, and 13 were female. Forty-three babies were normal, one was stillborn, and one was deformed; 42 are living and well. Table 1 lists the weights of babies born to women before and after the jejuno-ileostomy.

Types of Bypass

Jejuno-ileostomy had been performed on all the obstetric patients. The jejunum was divided 37 centimeters (cm.) (15 in.) or 35 cm. (14 in.) below the ligament of Treitz and anastomosed end-to-side to the terminal ileum 25 cm. (10 in.), 20 cm. (8 in.), or 10 cm. (4 in.) above the ileocecal junction. In one case, 25 cm. (10 in.) of jejunum was anastomosed end-to-end to 30 cm. (12 in.) of terminal ileum.

Method of Delivery and Anesthesia

A total of 28 patients delivered spontaneously, three by forceps, eight by cesarean (C) section, and one by breech extraction. Five patients received general anesthesia, four received saddle spinal, three had epidural blocks, three had pudental blocks, 16 had medical analgesia, and one had no anesthetic.

Table 2 lists the gestational ages of the infants. Thirty-six were delivered between 37 and 42 weeks' gestation. One pair of twins was born after 33 weeks' gestation.

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Eleven patients had elevated blood sugar determinations before jejuno-ileostomy. None of these patients had problems related to diabetes mellitus during pregnancy or delivery.

Complications of Pregnancy

A total of 28 women had 35 babies with no complications during pregnancies. There were five cases of complications of pregnancy. One involved electrolyte deficiency and nutritional anemia requiring 2000 milliliters (ml.) of whole blood by transfusion and leg edema secondary to deep femoral thrombosis. Another was associated with perirectal abscess and nutritional anemia, requiring 1000 ml. of whole blood by transfusion. An exploratory laparotomy was performed on one woman at 36 weeks' gestation for suspected intestinal obstruction. No obstruction was found, but dilated loops of the small bowel were seen. The other two cases of complications involved pre-eclampsia and benign hypertension.

TABLE 1
WEIGHTS OF BABIES BORN TO WOMEN BEFORE AND AFTER BYPASS SURGERY FOR OBESITY, WASHINGTON, GEORGIA, 1963-1968

Weights of Babies Before Bypass Surgery	Weights of Babies After Bypass Surgery
1. 2778 g. (6 lbs., 2 oz.)	2721 g. (6 lbs.)
2. 3416 g. (7 lbs., 8½ oz.)	3345 g. (7 lbs., 6 oz.) 3089 g. (6 lbs., 13 oz.)
3. 3458 g. (7 lbs., 10 oz.) 2948 g. (6 lbs., 8 oz.) 3543 g. (7 lbs., 13 oz.)	2438 g. (5 lbs., 6 oz.)
4. 2608 g. (5 lbs., 12 oz.) 2154 g. (4 lbs., 12 oz.) 2530 g. (5 lbs., 9½ oz.)	2126 g. (4 lbs., 11 oz.)
5. 3771 g. (8 lbs., 5 oz.)	3571 g. (7 lbs., 14 oz.)
6. 3629 g. (8 lbs.) 2608 g. (5 lbs., 12 oz.)	2296 g. (5 lbs., 1 oz.)
7. 3515 g. (7 lbs., 12 oz.) 3912 g. (8 lbs., 10 oz.)	3430 g. (7 lbs., 9 oz.)
8. 3599 g. (7 lbs., 15 oz.) 3317 g. (7 lbs., 5 oz.) 3317 g. (7 lbs., 5 oz.)	1642 g. (3 lbs., 10 oz.) 1782 g. (3 lbs., 15 oz.) (twin births)
9. 3005 g. (6 lbs., 10 oz.) 3364 g. (7 lbs., 7 oz.)	2240 g. (4 lbs., 15 oz.)
10. 3728 g. (8 lbs., 3½ oz.) 3884 g. (8 lbs., 9 oz.)	3814 g. (8 lbs., 6½ oz.)
11. 3968 g. (8 lbs., 12 oz.)	3629 g. (8 lbs.)
12. 3261 g. (7 lbs., 3 oz.)	2891 g. (6 lbs., 6 oz.)
13. 3416 g. (7 lbs., 8½ oz.)	3191 g. (7 lbs., ½ oz.)
14. 3629 g. (8 lbs.)	2126 g. (4 lbs., 11 oz.) 2252 g. (4 lbs., 8 oz.) (twin births)
15. 3472 g. (7 lbs., 10½ oz.)	2693 g. (5 lbs., 15 oz.)
16. 3685 g. (8 lbs., 2 oz.)	3033 g. (6 lbs., 11 oz.)
17. 3472 g. (7 lbs., 10½ oz.)	2693 g. (5 lbs., 15 oz.)

TABLE, 2
GESTATIONAL AGE, IN WEEKS, OF BABIES BORN TO JEJUNO-ILEOSTOMY PATIENTS, WASHINGTON, GEORGIA, 1963-1968

	Gestational Age (Weeks)						
	42	41	40	39	38	36	33
Number of Babies	3	1	26	2	2	2	1

Complications of Labor

There were seven patients who had complications during labor, as follows: (1) placental insufficiency requiring C section; (2) prolapsed cord with breech presentation and delivery of a stillborn baby; (3) cephalopelvic disproportion requiring C section; (4) fetal distress requiring C section; (5) hydrocephalic baby requiring C section; (6) premature labor at 36 weeks' gestation with twin births and repeat C section; (7) premature labor at 33 weeks' gestation with twin births. Three babies were delivered by C section because of previous C sections. Twenty-six mothers had 31 babies with no complications of labor.

Complications of the Newborn

These included hydrocephalus, prematurity in two sets of twins, a stillborn due to prolapsed cord with breech delivery, and a crib death at 9 weeks of age of one of the twins.

Discussion

It is interesting to note that one patient refused to release information concerning her delivery. She said that the child was all right, but she was so unhappy about her post jejuno-ileostomy side effects that she did not want to encourage anyone else to have this surgery.

Abdominal panniculectomy was performed on one patient following marked weight loss due to a redundant abdominal panniculus. The author thought the tight, flat abdomen might cause problems as the uterus enlarged. During pregnancy the abdomen was quite tight; however, she delivered a healthy, 3395 gram (g.) (7 lb., 9 oz.) baby without difficulty.

In five cases, labor was induced by oxytocin synthetic (Pitocin) or rupture of membranes.

One patient was 13 years old at the time of the jejuno-ileostomy. She has had two normal deliveries since her surgery. One patient had her first baby before the jejuno-ileostomy surgery, and a second

after surgery. Following her second delivery, her bypass was taken down, and normal bowel continuity was established.[6] She gained back all of the weight she had lost and added 11.8 kg. (26 lbs.). She subsequently delivered her third baby.

One patient had a C section for her first delivery, breech vaginal delivery for the second and third deliveries, and seven miscarriages before the jejuno-ileostomy. Following the jejuno-ileostomy, she delivered vaginally without difficulty.

One patient spontaneously delivered a set of twins in her car on the way to the hospital; her mother assisted. Gestational age of the babies was 33 weeks, and their weights were 1642 g. (3 lbs., 10 oz.) and 1782 g. (3 lbs., 15 oz.). They were hospitalized and progressed uneventfully until they weighed over 2270 g. (5 lbs.), then they were sent home. One twin was later found dead in her crib at 9 weeks of age. An autopsy was not obtained, and cause of death was not determined. It was classified as a crib death.

Anemia is rarely a problem after bypass surgery. Two patients did require blood transfusions, however, as a result of anemia, secondary, in one case, to a bleeding rectal fistula and in another, to poor health habits and multiple chronic illnesses.[6]

It is recommended that patients not become pregnant until a year after surgery (or the primary weight reducing period), even though two of these patients delivered at 10 and 13 months after the jejuno-ileostomy without difficulty. Everett reported a malnourished infant resulting from a pregnancy soon after the jejuno-ileostomy.[7]

Sterility is frequently noted in obese patients. One patient was married 2 years without conceiving and after her jejuno-ileostomy surgery had three normal pregnancies. Stein Leventhal Syndrome was noted in two patients and may contribute to sterility associated with obesity. One patient had bilateral ovarian wedging at the time of jejuno-ileostomy and later delivered a normal baby. Another patient had a 6-year history of sterility in two different marriages. During surgery for jejuno-ileostomy, a bilateral ovarian wedge resection was done, and the patient subsequently became pregnant. Anovulatory menstruation is also frequently observed in obese patients and often regular menses follow jejuno-ileostomy.

One patient presented late in pregnancy with a low serum protein. This was treated with 10 days of hyperalimentation, and her pregnancy subsequently proceeded normally. The lowering of elevated blood sugar appears to benefit post-jejuno-ileostomy patients, especially those who become pregnant.[1-3]

Johansson[9] reported markedly reduced hormonal serum levels after oral contraceptive ingestion following jejuno-ileostomy, as compared with normal control patients. The usual oral contraceptives cannot be considered a dependable anovulatory agent in this setting, although many of the author's jejuno-ileostomy patients have taken oral contraceptives with no failures reported.

Conclusions

1. The weights of babies born to mothers who have had jejuno-ileostomy surgery, when compared with those born prior to such surgery, are uniformly smaller, but not enough to adversely affect the health of the babies.
2. Prenatal care and delivery of most pregnancies after the jejuno-ileostomy is essentially the same as other pregnancies.
3. Jejuno-ileostomy patients under 161.8 kg. (356 lbs.) can be advised to get pregnant with the expectation of good results and minimal risks.
4. Pregnancy is not advised during the first year following jejuno-ileostomy, but if pregnancy occurs it will probably have a successful outcome.
5. Obstetricians managing post-bypass patients should be familiar with problems encountered after such surgery.
6. Panniculectomy after marked weight loss in one patient did not complicate pregnancy.
7. Long-term follow-up and in-depth intelligence testing of babies born to mothers who have had bypass surgery would be desirable to further evaluate the advisability of pregnancy after jejuno-ileostomy.

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A definite need exists for improved reporting methods in order to accurately define immunization levels.

An Evaluation of the First-Grade Immunization Level Reporting System in Whitfield County, Georgia

FRANK M. HOUSER, M.D., *Dalton**

In the last several years, there has been a growing concern in the United States regarding the inadequacy of immunization levels among our children. The fear of epidemics from preventable diseases, especially polio, is predicated on the progressively declining levels of immunizations among school-aged children being reported from the nation's schools. It is the purpose of this paper to evaluate the reporting system in Whitfield County, Georgia, to determine if errors in data collection are producing an erroneous basis for concern. (Whitfield County contains two systems: the County and Dalton City.)

Methods

In Georgia, immunization data are generated from the state's first-grade school population. No comprehensive attempt is made to collect similar data on younger children, except to record the number of doses of vaccine dispensed by the Department of Human Resources.

Children entering the first grade are required by state law to present a certificate of immunization as a prerequisite for admission. If the child fails to present such a certificate, his parents are required to do so within 120 days. Each school then submits a report to their county health department stating the number of first graders who are adequately immunized, provisionally certified, specially certified, and non-immunized.

The Whitfield County study assumed that the above mechanism has potential shortcomings which could affect the quality of information generated. The school systems in Georgia do not have a unified policy regarding consequences if the certificates are not presented (i.e., children are not expelled from school for failure to provide proof of immunization). Thus, it was assumed that many non-immunized children may have had adequate inoculation, but their parents never provided this information to the schools.

In order to evaluate this hypothesis, the following process was developed:

Utilizing persons employed under the Comprehensive Employment and Training Act of 1973 (CETA), all first-grade records in the Whitfield County and Dalton City School Systems were evaluated individually as to immunization adequacy. If a child's record indicated that he had less than an adequate certificate, the child's name, parent's name, address, phone number, and private physician's name were obtained. The immunization records of each child in this group were checked at the county health department to determine if adequate immunizations had, in fact, been given at the health department, and the parents were simply lax in presenting the information to the school. If a private physician were listed, his office was contacted, and his immunization records regarding the child were checked. If no additional immunization information could be obtained using these procedures, an attempt was made to locate the parents of inadequately immunized children using the home address or telephone number given on the school record. If the parents could not be contacted by mail or telephone, the CETA worker visited the home to obtain the needed information.

Results

The Georgia Department of Human Resources reported an immunization level of 74.3% for the Whitfield County Health System and 71.1% for the

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Dalton City System, using the customary reporting system in school year 1976-77. Following the initial evaluation of school records by a CETA worker in 1978, the immunization levels increased to 83.16% for the county and 76.18% for the city for the 1977-78 school year. (This increase over the previous year may have been due in part to the public's positive response to media coverage regarding immunization deficiencies.) After the comprehensive evaluation procedure using the CETA personnel had been completed, the percent of adequately immunized children in the first grade increased to 93.06% for the county and 89.86% for the city.

The two school systems evaluated had a total first-grade enrollment of 1,744 children. In the initial record search, 1,402 were found to have adequate certificates. This increased to 1,605 following the comprehensive evaluation procedure which took 4 weeks to complete. A total of 203 children, or 11.63% of all first graders, were found to have been adequately immunized and yet had been reported as inadequately immunized. (One possible explanation for this error was that the children received the necessary immunizations in the 4-week study period. Although this is unlikely, it would tend to support the advisability of individually contacting parents of non-immunized children.)

The results of this study suggest a need for improved reporting mechanisms to accurately define the level of immunization need in Georgia schools.

More on Voluntary Effort — Support From Administration Officials

The Voluntary Effort (VE) has received support from two high Carter Administration officials. During a meeting of the National Steering Committee on Voluntary Cost Containment in Washington, D.C., **Barry Bosworth,** chairman of the Council on Wage and Price Stability, and **Robert Strauss,** special counsel to the President, said that President Carter "wanted us to come here today to encourage you in your efforts to contain health care costs." Although the Administration failed to obtain enactment of hospital cost containment legislation, Strauss said the Administration recognizes the significant progress of voluntary programs in the fight against inflation.

Bosworth said both he and Strauss were "eager to work with the VE on a cooperative basis." Hospitals are "one of the very few industries in which deceleration (of the rate of inflation) has succeeded," Bosworth said, "and this is significant considering the rate of inflation in the rest of the economy." He added that "the design of the Voluntary Effort addresses the unique problems of its own field better than any other industry the Council on Wage and Price Stability has seen."

Bosworth recommended strengthening the VE by screening the performance of individual hospitals, taking into account local conditions and differences. He added, however, "the program would be more effective with teeth behind it in the form of standby controls."

Following the steering committee meeting, **Paul Earle,** executive director of the VE, announced at a press conference that the rate of growth in hospital expenditures during the first 7 months of the year was 12.8% — the lowest rate since 1974. "The decrease in the rate of increase in hospital expenditures by 2.8% (from 1977) indicates a trend which shows that the VE goal of a 2% reduction will definitely be accomplished this year," Earle said.

James Sammons, M.D., executive vice president of the AMA, told those at the press conference that the medical profession is totally committed to the VE, outside as well as inside of hospitals. Physicians have been reducing the rate of escalation of fees, Dr. Sammons said, noting that many medical societies have established commissions on the cost of medical care. "A call for moderation in the rate of physicians' fees by **Tom E. Nesbitt, M.D.,** AMA president, has been widely supported," he noted. Dr. Nesbitt was commended by the VE committee for his effort.

Dr. Sammons said the AMA has been meeting with corporate leaders to discuss cost factors in health care provisions and noted that the AMA has just issued a cost containment kit to its constituent medical societies.

Alexander McMahon, president of the American Hospital Association, and **Michael Bromberg,** executive director of the Federation of American Hospitals, predicted that the next Congress will be even more resistant to federal hospital control proposals because of the success of the VE.

"The success of the Voluntary Effort in containing hospital costs was the single most important factor in winning Congress' support in the fight against any form of the Administration's proposed hospital revenue caps," said McMahon.

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We obviously do not cause this digestive process to occur. We are not even consciously aware of all that is happening to our bodies during this process. Our digestive system was designed by God, and only He can guide us in its correct usage — not we ourselves, the commercial food industry, or any government agency. So don't assume that those who make instant breakfast, imitation orange juice, or plain white bread know the truth about what your body needs. That applies as well to those who manufacture vitamin pills and nutritional supplements. They cannot improve on the master design that brought us here and allows us to survive from day to day.

Gentlemen, let's accept the challenge to improve our knowledge of nutrition and learn new ways to incorporate this knowledge into the practice of medicine. Our nutrition committee will begin nourishing your thoughts in this regard very soon.

Sincerely yours,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

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The Holidays — Hallelujah or Hell

DECEMBER IS THE MONTH that heralds the Christmas holidays, and with it come depression, dyspepsia, drunkenness, and drivenness. Each year articles appear describing and explaining the increase of depression and alcoholism during the holiday season. And certainly one of the more common expressions heard among friends in stores, on the streets, is "I'll be glad when it's finally over!" The position is one of a person driven and harassed, hoping to make it through a pressured period with mind, body, family, and possibly pocketbook still intact.

What an ironic contrast this is to the season that is supposed to bring peace and love, a season intended to remind us of God's radical intervention on earth, with a promise of reconciliation with Him and new hope of becoming a fulfilled and whole people. The contrast between the common experience and the true significance of Christmas is so outrageous it must be diagnostic of some serious malady among us, of distorted priorities, and a mindset that inevitably blocks us from God's intent.

We are people who have become seduced or intimidated by the false gods of naturalism, humanism, and materialism. These evanescent "religions" have articles of faith telling us our very existence is but chance arrangement of molecules; there is no special meaning or destiny to our lives so we had best grasp all we can right now; finally, this philosophy suggests we are supposed to reach our highest achievement and develop benignly with fulfillment apart from God. Our bookstores are replete with pop psychology espousing these ideas with promises to bring the faithful to power, prestige, and pleasure. Paul warns us about this in Colossians 2:8 when he says, "Don't let others spoil your faith and joy with their philosophies, their wrong and shallow answers built on men's thoughts and ideas instead of on what Christ has said." (Living Bible).

If the Christmas story is true, then C. S. Lewis's statement is singularly significant "Our Lord finds our desires not too strong but too weak. We are half-hearted creatures fooling about with drink and sex and ambition when infinite joy is offered us, like an ignorant child who wants to go on making mud pies in a slum because he cannot imagine what is meant by the offer of a holiday at the sea. We are far too easily pleased."[1] There is something within us all that whispers, surely there is more to life than what is suggested through the religions of naturalism, humanism, and materialism. The Christmas message resounds with the affirmation of God's love as He broke into human history nearly 2,000 years ago. If the astounding significance of this event escapes us, then "The world becomes a strange, mad, painful place, and life in it is a disappointing and unpleasant business, for those who do not know about God. Disregard the study of God, and you sentence yourself to stumble and blunder through life, blindfolded as it were, with no sense of direction and no understanding of what

surrounds you. This way you can waste your life and lose your soul."[2] The Bible is critically relevant today, revealing to us how to know God through His son Jesus Christ, to appropriate His love, and to share it with others. This is the exciting promise of Christmas, then, to be touched anew by the miracle of Jesus' birth and reminded of the necessity of our spiritual rebirth into His kingdom before our lives can have any real stability and significance.[3]

James D. Mallory, Jr., M.D.
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An Update on Voluntary Effort

IN A DEBATE of the proposed administration bill in November 1977 to limit the annual increase of hospital expenditures to 9%, Dr. Dan Rostenkowski of Illinois challenged representatives of the health care industry to control costs voluntarily to prevent imposition of federal government controls. Implied was the threat that government controls would surely be enacted if voluntary control by the health care industry were not. In November 1977, representatives of the American Hospital Association, the American Medical Association, and the Federation of American Hospitals (FAH) jointly established the "National Voluntary Effort."

On January 24, 1978, representatives of the Medical Association of Georgia (MAG), the Georgia Hospital Association, and the Georgia Chapter of the FAH organized the "Georgia Voluntary Effort for Cost Effectiveness in Health Care." The representatives of MAG at the organizational meeting included members of MAG's committee on Cost Accountability. Subsequently, MAG appointed Dr. Dan Jordan from Atlanta, Dr. Bill McDaniel from Dalton, and me to represent this group. The committee has since been increased and now includes representatives from Blue Cross/Blue Shield of Atlanta, Blue Cross/Blue Shield of Columbus, Health Insurance Association of America, and the Georgia Department of Medical Assistance (representing the Governor's Office).

The formation of the Voluntary Effort was reported to the 1978 House of Delegates of MAG and that body adopted the following recommendations in support of the Voluntary Effort:

1. That MAG support the concept of the Joint Steering Committee for Georgia on Voluntary Cost Containment and that the extent of support in staff and financial assistance be determined by the Board of Directors and/or Executive Committee.
2. That although MAG will be providing Staff assistance to the Joint Steering Committee, MAG and its members should retain the right to independent action on any recommendations which may ultimately come from the Joint Steering Committee.

To date, the primary thrust of the Joint Committee has been to reduce the rate of increase of hospital expenditures. Phase I of the program has consisted in obtaining provisional certification of hospitals as cost-effective hospitals. Provisional certification by hospitals has been obtained by having both the hospital governing board and the hospital medical staff approve resolutions agreeing to control hospital expenditures as much as possible and to support the program and continuing activities of the Georgia Voluntary Effort. Over 100 hospitals in the state have been provisionally certified.

Phase II of the Voluntary Program has recently been approved by the state's Steering Committee. This phase will require the state's Steering Committee to deter-

mine a reasonable reduction in the percentage of increase in statewide hospital expenditures which can be achieved in 1979 and to communicate to health care providers and the general public the need for serious commitment to this goal. In an effort to measure the progress toward achieving a reduced rate of increase in hospital expenditures, the state's Steering Committee will translate the state numerical goal into individual hospital limitation goals. Recognizing that hospitals vary greatly both in size and type of community setting, the methodology for determining each hospital's goals has been outlined with this in mind. The committee recognizes that many hospitals in the state have been practicing cost containment for many years and, accordingly, have relatively low rates of expenditure increases in comparison with other hospitals. Also, there are provisions for balancing this divergence into districts whose participating hospitals are relatively equal.

It should be emphasized that both the Georgia plan and the national plan are still *voluntary*. It is my belief that a voluntary effort of the nation's health care providers is the only way to achieve a lasting decrease in health care expenditures while continuing to maintain a high quality of health care and an equitable distribution of health care services throughout the state. The alternative to this effort, mandatory and nonflexible government controls, is unacceptable to the vast majority of physicians and other health care providers. The Voluntary Effort has already had a positive impact. It appears that there will be a reduction in hospital expenditures of at least two percentage points (13% increase in 1978, compared to 15% increase in 1977) in the State. I feel that we can expect even greater reductions in the increasing costs of health care in the future if we continue to work together to accomplish this task. Hopefully, our representatives in Washington will see the value of our plan and will allow us to proceed with this task without unnecessary controls.

H. Duane Blair, M.D.
Chairman, Cost Accountability Committee

Blue Cross and Blue Shield Coverage Plans for Second Opinions

Twenty-seven Blue Cross and Blue Shield plans will reimburse for second opinions on the need for elective surgery recommended by physicians. Many more plans are expected to be involved in second opinion surgery programs in the near future, Blue Cross-Blue Shield reported.

Under the program, all charges related to the second opinion, including the consulting specialist's fees, x-rays, and laboratory tests, are covered by the plans. If the second opinion differs from the first, some plans pay for a third opinion to help the subscriber decide whether or not to have surgery.

Walter J. McNerney, President of the Blue Cross and Blue Shield Associations, said a major purpose of the pre-surgical consultation programs is to determine the extent to which an additional independent opinion results in significant savings or in improvement of patient care by reducing the incidence of elective surgery.

The Blues released the statement on second opinions to coincide with the scheduled official launching of the Department of Health, Education and Welfare's (HEW) second opinion program for Medicare and Medicaid. The Government plans an extensive publicity campaign to encourage the public to seek second opinions when suitable.

In a comment upon the HEW program, James H. Sammons, M.D., Executive Vice President of the American Medical Association (AMA), said "The concept of second opinions is not new to the medical profession. The AMA has for years supported voluntary consultation. The Association's Principles of Medical Ethics specifically state that, 'A physician should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of medical service may be enhanced thereby.'

"The Department of HEW claims that its national second opinion program will be cost reducing. However, such a program promises to increase utilization of physician services as Medicare and Medicaid patients across the country are urged to seek a second opinion before all non-emergency surgery. Short-term results of several experimental second opinion programs have not provided clear evidence that a national program of this type will either improve the quality of care or reduce health costs."

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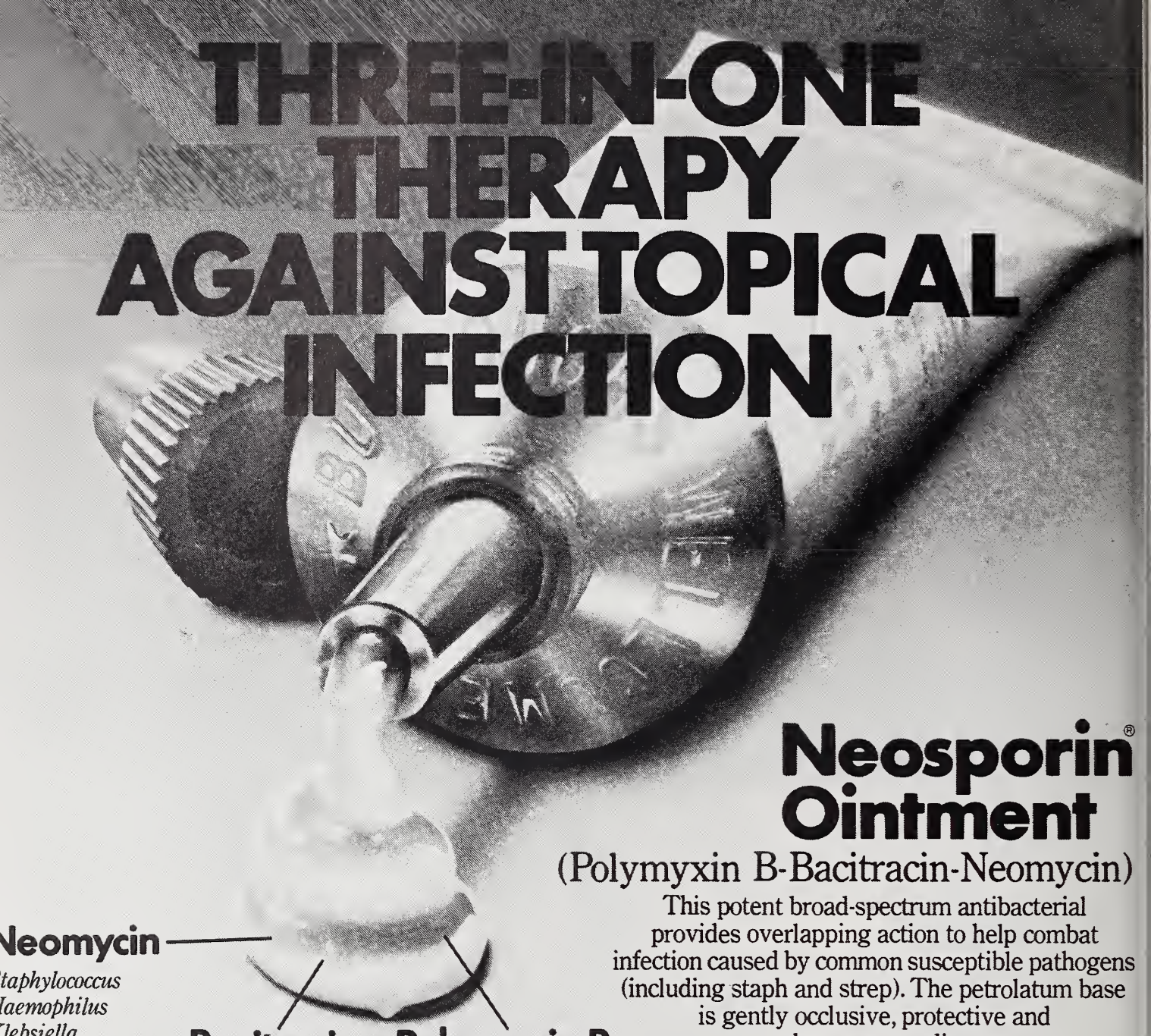
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Complete literature available on request from Professional Services Dept. PML.

Maxillofacial Prosthetics — A Better Quality of Life

GARY L. GOLDEN, D.D.S., *Atlanta**

CANCER CAN OCCUR at any age and attack any part of the body. Carcinomas of the head and neck area involve about 20-25% of malignant tumor cases. Radical surgery is often required, and this is often preceded or followed by aggressive radiation therapy in an attempt to eradicate the disease or attain local control. Very often, unsightly and incapacitating defects of the head and oral cavity are left as a result of such treatment. If radiation therapy is utilized, the tissues are friable and prone to osteoradionecrosis.

The treatment by no means ends with the elimination of the disease, for these patients must be further rehabilitated. This sometimes requires prosthetic correction of the defects to improve their appearance and enable them to be employed again. Their chances for a better life are improved, and they can be lifted from the deep valley of despair and depression which commonly accompanies this disease. The psychosocial factors must be given consideration, and psychological counseling is therefore often suggested as an adjunct to prosthetic therapy. A great majority of the patients respond well to the prosthetic management of the defects.

The maxillofacial prosthodontist often sees the patient with cancer of the head and neck more frequently during the rehabilitative phase than does the surgeon and is therefore more familiar with the oral and systemic condition of the patient. He is in a good position to watch for early detection of recurrent disease, since on follow-up appointments the patient's head and neck are thoroughly examined. When the team approach is utilized, the surgeon and maxillofacial prosthodontist can have advance rehabilitative planning sessions and thereby often avoid unfavorable post-surgical tissue contours. If the surgeon is aware of our prosthetic problems, he is better able to understand why we might suggest alternative surgical approaches. For example, in a partial maxillectomy case, if the surgical incision and subsequent bone cut are made through the socket of the adjacent tooth rather than directly adjacent to the remaining tooth, then the bone on the wall of the alveolus is retained. In that case, the tooth is a more favorable abutment for the removable prosthetic appliance, and its longevity will be extended.

Defects of the head and neck area can be grouped into three categories: intraoral defects, extraoral facial defects, and a combination of the two. Intraoral prosthetic appliances include immediate surgical obturators inserted at the time of surgery, intermediate obturators used when the defect begins to heal, and definitive obturators used when the patient is completely healed. In the mandibular arch, resection and repositioning appliances are fashioned to fill in spaces and help correct the excessive deviation of the mandible towards the defective side, resulting from the pull of the healthy masticatory muscles. Other prosthetic appliances include the dynamic bite opener, speech bulbs and obturators, nasopharyngeal stents, palatal lift and palatal drop appliances along with compression stents,

* Dr. Golden has a limited specialty clinical practice of prosthodontics and maxillofacial prosthetics and teaches crown and bridge prosthodontics at Emory University Dental School on a part-time basis. His address is 5675 Peachtree-Dunwoody Road, Atlanta, Georgia 30342.

prosthetic ears, orbital prosthesis with an acrylic eye, and noses utilizing soft, flexible lifelike materials.

There are many other ramifications of maxillofacial prosthetics that are too numerous to discuss in detail here. They include management of the irradiated patient, management of the patient receiving chemotherapy, prosthetic coverage for the plastic surgeon and the otolaryngologist in their treatment of congenital diseases, such as cleft palate, cleft lip, facial trauma, and the use of keloid compression stent earrings.

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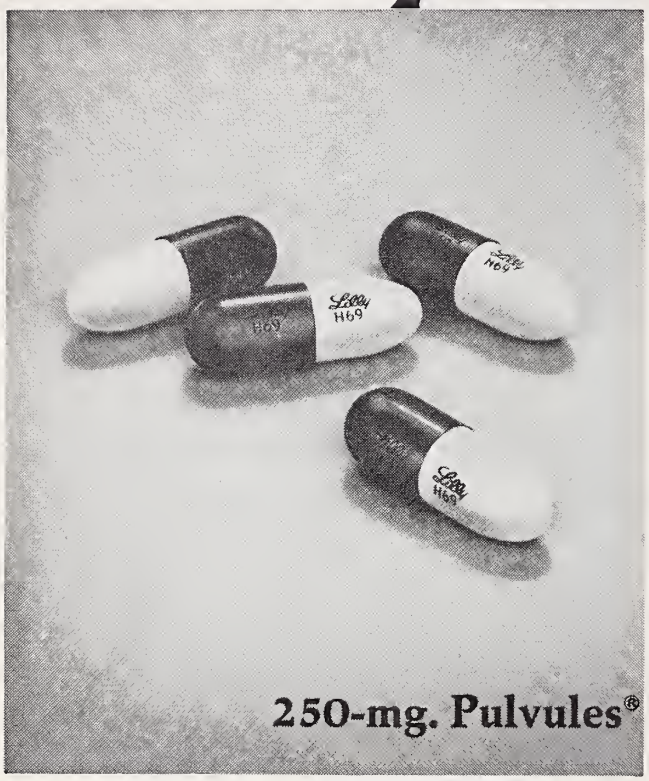
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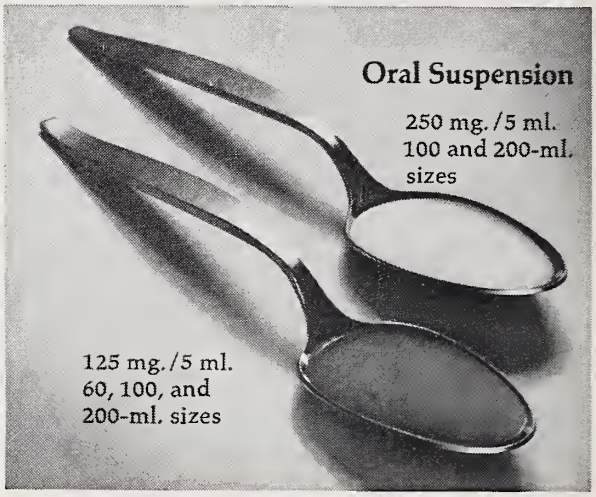
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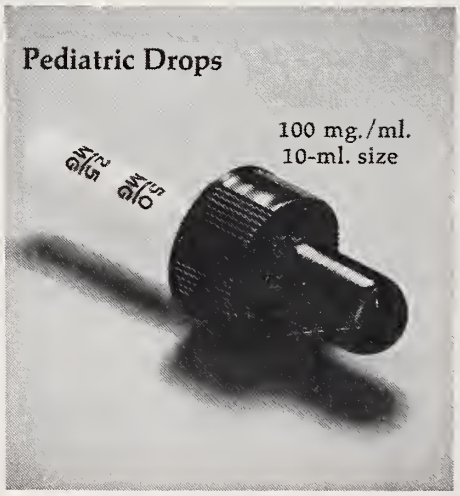
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Electrocardiographic Abnormalities in Myocarditis

BARRY D. SILVERMAN, M.D., *Atlanta**

ACUTE INFLAMMATORY PROCESSES involving the heart have been described in almost every known bacterial, viral, rickettsial, mycotic, and parasitic disease. Myocarditis can be difficult to diagnose. Electrocardiographic abnormalities are frequent but nonspecific. Changes in the electrocardiogram (EKG) and the absence of other clinical evidence of myocarditis occur in 10-33% of patients with common infectious diseases. Acute viral myopericarditis represents one of the most common infectious illnesses affecting the heart. Table 1 lists the electrocardiographic abnormalities commonly associated with viral infections.

The electrocardiographic changes in acute myocarditis generally reveal T wave changes, either reduced amplitude or inversion, often in the left precordial leads. The EKG usually reverts to normal as the illness subsides; however, T wave inversion may remain for weeks or even months. Sinus tachycardia may be the only arrhythmia present and is usually suggestive of myocarditis when there is persistence of the tachycardia during the convalescent phase. Premature ventricular contractions are the next most common arrhythmia. It may occur in the absence of any other electrocardiographic abnormalities. Atrial, ventricular, or peripheral conduction defects are unusual in mild forms of myocarditis. These defects usually occur in more widespread, severe disease, are associated with a less favorable

TABLE 1
ELECTROCARDIOGRAPHIC ABNORMALITIES ASSOCIATED WITH VIRAL INFECTIONS

ST and T Wave Changes	Conduction Disturbances*	Arrhythmias
Poliomyelitis	Poliomyelitis	Poliomyelitis
Coxsackie	Influenza	Coxsackie
Mumps	Mumps	Infectious Hepatitis
Rubeola	Rubeola	Rubeola
Herpes Simplex	Varicella	Herpes Zoster
Rubella	Rubella	
Rabies	Infectious Mononucleosis	
Lymphocytic Choriomeningitis		

* Including PR Prolongation, AV Block, and Bundle Branch Block.

* Dr. Silverman is a cardiologist at Northside Hospital in Atlanta. His address is 1000 Johnson Ferry Rd., Atlanta, Georgia 30342.

Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

prognosis, and may persist after the acute illness has subsided. Occasionally, patients experience electrocardiographic changes simulating myocardial infarction. Q waves may occur, and there may be deep symmetrical inversion of the T wave. Changes consistent with pericarditis may occur and are more common with the enteroviruses.

Myocarditis may also result from bacterial, spirochetal, rickettsial, protozoal, and helminthic infections. The electrocardiographic abnormalities characteristic of bacterial infections are noted in Table 2.

AV block, bundle branch block, and changes mimicking myocardial infarction are associated with tertiary syphilis. These result from diffuse gummatous lesions involving the myocardium. Myocarditis is also usually associated with leptospirosis. T wave changes are common, as is bradycardia, and complete heart block can occur. There is usually prolongation of the PR and QT interval.

Rickettsial myocarditis results from typhus, Rocky Mountain spotted fever, or Q fever and is associated with nonspecific ST and T wave changes. Both leptospirosis and rickettsial infections may result in congestive heart failure, hypertension, and circulatory collapse.

Mycotic infections of the myocardium usually result in necrotizing lesions with focal myocardial granulomas or abscesses. Electrocardiographic abnormalities may be limited to T wave changes. Pericarditis is common, as are arrhythmias. Chagas disease is the most common protozoal infection to involve the heart. Electrocardiographic features are characteristic and include right bundle branch block, left anterior hemiblock, symmetrically inverted T waves, and frequent and multiform ventricular premature beats.

Helminthic infections may involve the myocardium. They are associated with focal muscle necrosis, myocardial abscess formation, and cyst formation which may develop from larvae in the myocardium.

ST and T wave changes are also seen in patients with trichinosis, echinococciasis, strongyloidiasis, and cysticercosis. Schistosomiasis may produce cor pulmonale with associated EKG changes.

Myopericarditis can often be a difficult disease to diagnose. Besides the classic features of myocarditis or pericarditis, it may present as a coronary mimic with chest pain typical of myocardial ischemia, progressive heart failure following a relentless course with a fatal termination, or an influenza-like illness and fever of uncertain origin. While the electrocardiographic changes are nonspecific, it is helpful to remember that new Q waves are rare. ST elevation over 5 mm. is unusual. There are usually no reciprocal ST changes when ST elevation is present, and T wave inversion over 7 mm. is uncommon. Myocarditis can be suspected when T wave changes are transient or variable and associated with long, severe pain that bears no relationship to the rather mild EKG changes. It is usually associated with an absence of enzyme rise or only a small transient elevation.

TABLE 2
ELECTROCARDIOGRAPHIC ABNORMALITIES ASSOCIATED WITH BACTERIAL INFECTIONS

ST and T Wave Changes	Conduction Disturbances*	New Q Waves or Changes Mimicking Myocardial Infarction
Diphtheria	Diphtheria	Bacterial, Endocarditis
Typhoid Fever	Typhoid Fever	Melioidosis
Scarlet Fever	Scarlet Fever	Tuberculosis
Meningococcemia	Acute Rheumatic Fever	
Staphylococcus	Tuberculosis	
Pneumonococcus		
Brucellosis		
Tetanús		

* Including AV and Bundle Branch Block

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Chiropractic Physical Examinations of High School Athletes in Georgia — A Preview of the Legal Issues

ROBERT N. BERG, *Atlanta**

THE MEDICAL PROFESSION, in general, has historically regarded the chiropractic as an "unscientific cult whose practitioners lack the necessary training to diagnose and treat human disease."[1] A number of reasons have been given to justify this position, ranging from a disdain for the chiropractic doctrine of a single cause of disease and a single cure effected by the manual manipulation of the spine to the fact that chiropractors are expressly prohibited by law from prescribing drugs or performing surgery.[2]

The medical profession's view that the chiropractic is an "unscientific cult" has obviously resulted in some ill feeling between the medical and chiropractic professions. More importantly, however, this view has also resulted in some interesting, and sometimes quite intricate, legal questions. For example, as far back as the early 1930's, courts were asked to determine whether chiropractors were qualified to testify as expert witnesses in personal injury suits[3] and whether chiropractors were within the protection of the physician-patient privilege.[4] More recently, suits have been instituted by chiropractic associations in Pennsylvania, New Jersey, and Illinois, and courts in those states will be determining the validity of allegations that the doctors, medical associations, and state medical boards have conspired, in violation of the antitrust laws, to refuse to deal with the chiropractors.

The medical profession's view of the chiropractic has also led to the question of whether a chiropractor is a "physician" for the purpose of performing physical examinations on high school athletes, and this question is currently the subject of a legal action pending in Lamar County, Georgia.

The Lamar County Suit

The dispute in Lamar County arose when 25 of the 26 members of the Lamar County Comprehensive High School football team were declared ineligible to participate in football because they had failed to satisfy the state requirement of having a physical examination performed by a "physician." Although the 25 members had been examined by two local chiropractors, the Standards Council for Georgia schools ruled that the term "physician" only meant either a medical doctor or an osteopath.

Subsequently, 23 of the 25 ineligible members of the Lamar County football team received physical examinations from medical doctors and thereby preserved

* Prepared at the request of the Medical Association of Georgia (MAG). Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to MAG, 1100 C & S National Bank Building, Atlanta, Ga. 30303.

their eligibility; two members of the team, however, did not receive new physical examinations.

The two Lamar County chiropractors, along with the Georgia Chiropractic Association, filed suit in Lamar County Superior Court and were successful in obtaining a temporary injunction which prohibited the local school board from enforcing its interpretation of "physician" as to the two members of the football team who did not get reexamined; in addition, the chiropractors and the Association sought a permanent injunction which would preclude the local school board from ever enforcing this interpretation.

As of this writing, the Lamar County Superior Court has accepted briefs from the parties to the lawsuit, and the Court is preparing to rule on the permanent injunction. Consequently, this appears to be an opportune time to preview the issues involved in this dispute.

The Definition of "Physician" Under Georgia Law

The Lamar County Superior Court is initially faced with the question of whether the term "physician" is defined under Georgia law. In that context, the Georgia Medical Practice Act (the "Medical Practice Act")[5] does not expressly define the term "physician," other than in connection with determining the legality of voluntary sterilizations, in which case a "physician" is defined as "a person duly licensed to practice medicine and surgery in Georgia without restriction. . . ."[6] Nevertheless, the Medical Practice Act is replete with references to the term "physician," while that term does not appear in the Georgia Chiropractors Act (the "Chiropractors Act").[7] Therefore, it may be argued that the Georgia Legislature intended to limit the term "physician" to medical doctors and osteopaths licensed under the Medical Practice Act.

Moreover, although there is no Georgia case holding directly that a chiropractor is not a "physician," courts in other states have held that a chiropractor is not a "physician" for the purposes of performing physical examinations required of applicants for automobile operator licenses[8] and executing death certificates,[9] and one court has held that a chiropractor could not use the title of "chiropractic physician."[10]

Restricted Nature of Chiropractic License

In addition to the issue of the definition of "physician" under Georgia law, the Lamar County Superior Court must also determine whether the performance of physical examinations on high school athletes is within the scope of the limited license granted to chiropractors. Pursuant to the Chiropractors Act, chiropractors have the right to:

> "adjust patients according to specific chiropractic methods and shall observe state, municipal, and public health regulations, sign death and health certificates, reporting to the proper health officers the same as other practitioners. Chiropractors shall not prescribe or administer medicine to patients, perform surgery, nor practice obstetrics or osteopathy."[11]

Thus, it may be argued by the chiropractors that, in light of this authorization to "sign health certificates," chiropractors who perform physical examinations on high school athletes are acting within the scope of their limited license.

Conversely, it may be argued that the statutory authority to sign health certificates must be read in light of the definition of "chiropractic" contained in the Chiropractors Act, which is limited to "the adjustment of the articulation of the human body, including ilium and coccyx, and . . . the use of electricity x-ray protography (sic), but the x-ray shall not be used for therapeutical purposes."[12] Consequently, it would follow from this interpretation that the signing of health certificates subsequent to the performance of physical examinations which extended beyond the definition of "chiropractic," such as examinations which entail the testing and diagnosis of the cardiovascular system for the purpose of determin-

ing whether high school children were physically able to participate in active contact sports, would not be within the scope of the chiropractor's limited license.

(Editor's Note: On October 26, 1978, the Lamar County Superior Court determined that a permanent injunction should not be issued to prevent the local school board from enforcing its interpretation of the term "physician." This determination was not based on the merits of the lawsuit, however, in that the Court ruled that the plaintiffs had failed to exhaust their administrative remedies. Consequently, it was not necessary for the Court to reach a decision regarding the intricate legal questions which are highlighted in the article above. Nevertheless, these legal questions will ultimately be answered, and therefore should remain of significant interest.)

Notes

1. American Medical Association, *Chiropractic: the Unscientific Cult,* 1966.
2. For a more comprehensive list of the reasons espoused by the medical profession to justify the position that the chiropractic doctrine is "unscientific," see American Medical Association, Department of Investigation Publication, OP-83 (1966).
3. See, e.g., *Johnson v. Peairs,* 3 P.2d 617 (Cal. Ct. of Appeals 1931).
4. See, e.g., *S. H. Kress & Co. v. Sharp,* 126 So. 650 (Miss. S. Ct. 1930); Annotation, 68 A.L.R. 176 (1930).
5. *Ga. Code Ann.* §84-901 *et seq.*
6. *Ga. Code Ann.* §84-933(b).
7. *Ga. Code Ann,* §84-501 *et seq.*
8. *Commonwealth of Pennsylvania Dept. of Transportation Hearing Board v. Pennsylvania Chiropractic Society,* 349 A.2d 509 (Pa. Commonwealth Ct. 1976).
9. *Colorado Chiropractic Ass'n v. State of Colorado,* 467 P.2d 795 (S. Ct. Colo. 1970).
10. *Beverungen v. Briele,* 333 A.2d 664 (Md. Ct. of Special Appeals 1975).
11. *Ga. Code Ann.* §84-509.
12. *Ga. Code Ann.* §84-501.

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Malpractice claims against Georgia physicians have continued to increase. A total of 335 claims had been filed as of October 25, 1978. In 1977, the total was 344. To help curb this trend, the Medical Association of Georgia (MAG) and St. Paul Companies are working together to organize a series of malpractice seminars in 1979. The curriculum being formulated is drawn from malpractice litigation that has occurred in Georgia. Experts in various specialty areas will be brought in. Their recompense, as well as other expenses incurred by these seminars, will be paid by MAG.

Those physicians attending and satisfactorily completing these seminars will be given a discount on their 1980 Professional Liability Insurance Premium, and as the care of the patient improves and claims drop, everyone's premium will come down!

There will be more information regarding these seminars appearing in future issues of the *Journal.* Let us hear from you. We need your support to make these seminars work.

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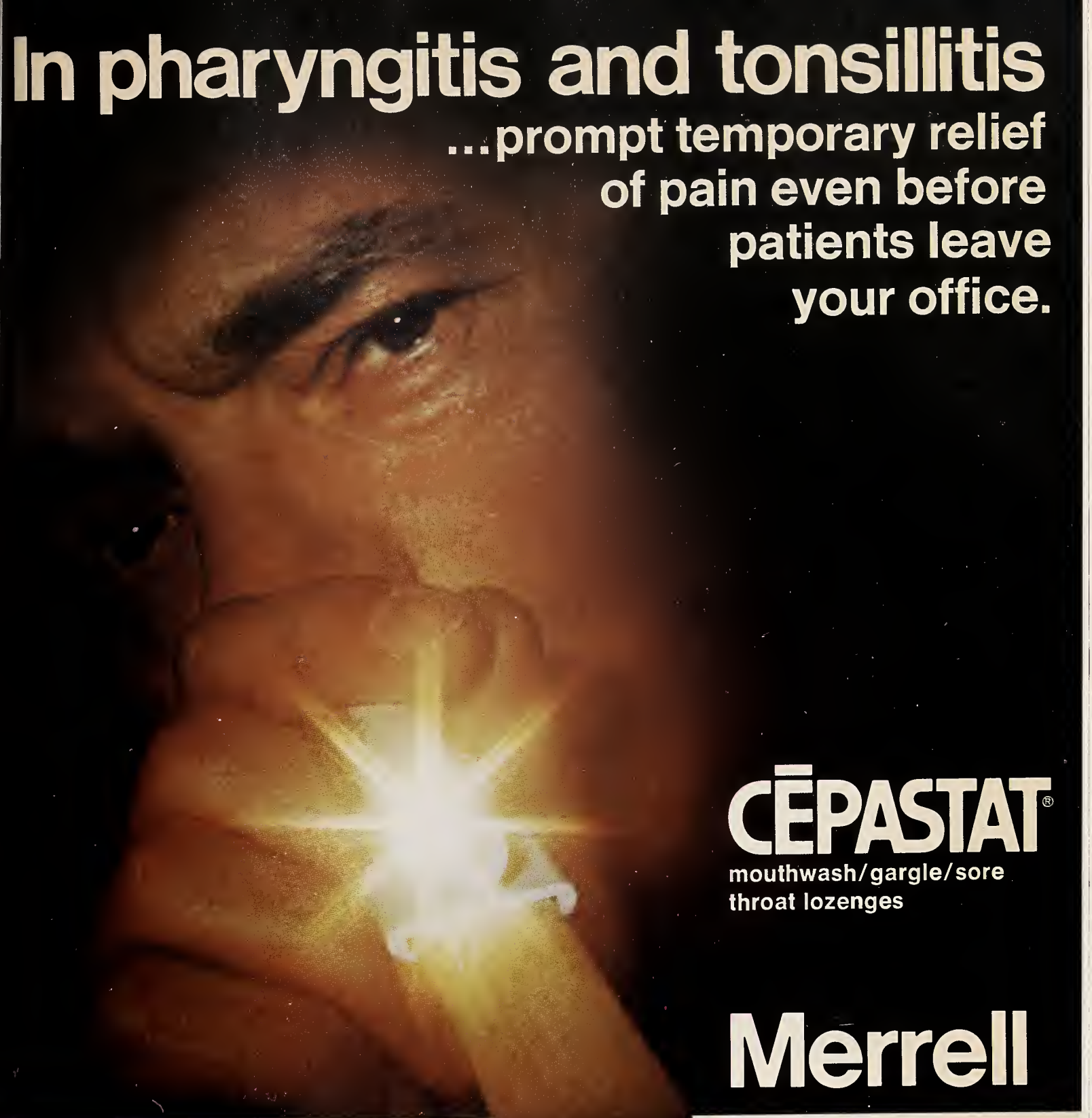
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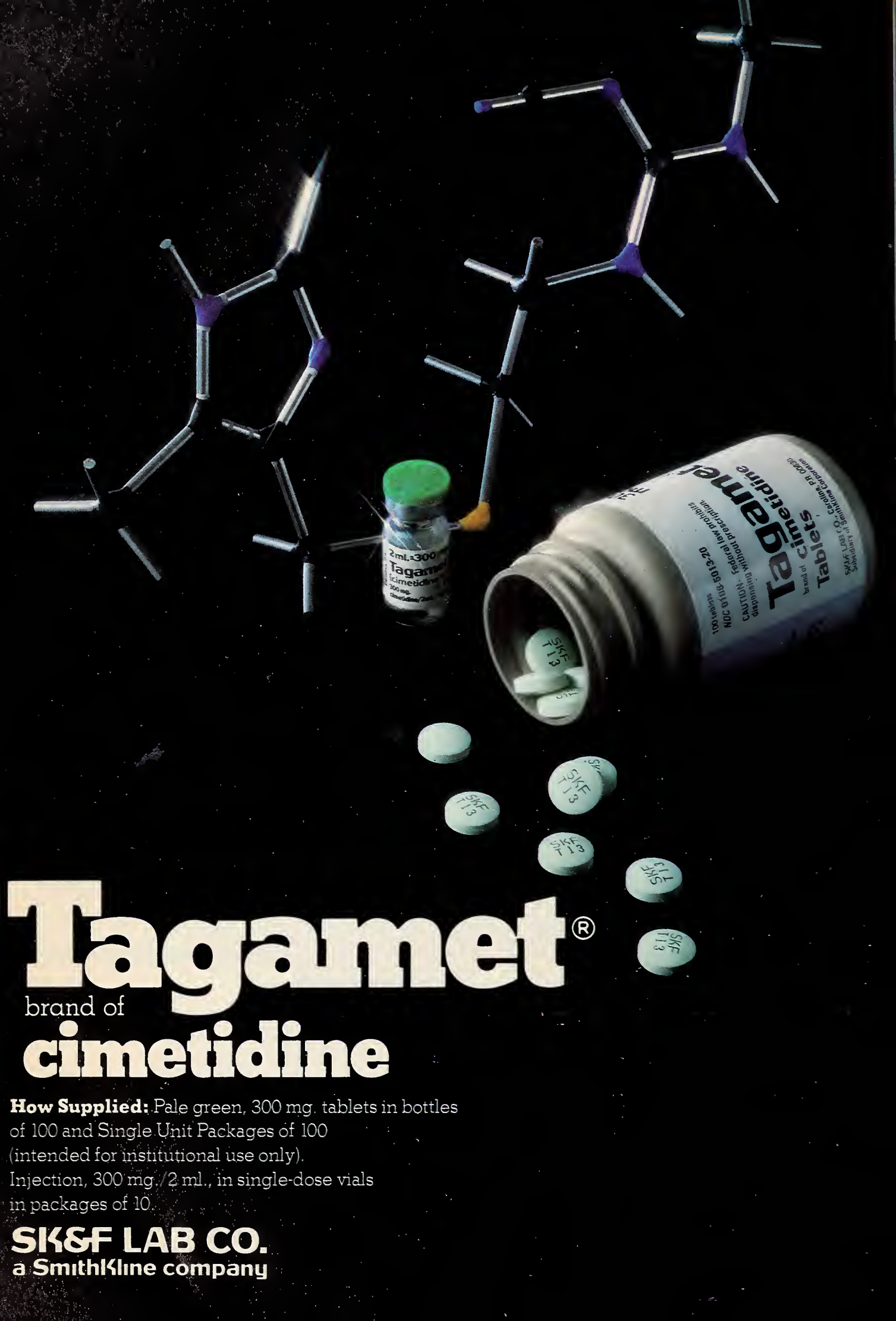
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A Flight of Fancy

*This little gem was sent to Dr. Warren Bostick by Daniel P. McMahon, M.D., of New York. Unfortunately, we cannot determine where it originally appeared. All we know is that it was authored by a Robert B. Howard, M.D., "Consulting Editor." Nevertheless, we are unable to resist sharing it. Our thanks, Dr. Howard.**

Flying an aircraft is much too serious a business to be left to the pilot. For far too long, pilots have enjoyed a kind of mystique which has permitted them to dominate the flight-care system in an unconscionable fashion. It is high time that we flight-care consumers asserted our fundamental rights.

I am tired of having the pilot tell me when I can board an aircraft, when I must buckle my seatbelt, at what altitude we will fly, and other comparable aspects of my flight-care consumption. The pilot, after all, is only one member of a flight-care team that also includes ticket sellers, boarding area personnel, cabin attendants, navigators, and copilots. The views of all of these people, experts in their respective fields, should be taken into consideration when flight care is being planned and executed. Obviously, the interests of the consumers must also be respected.

I suggest that what we need in the United States is a massive restructuring of the flight-care system that will free us of this unhealthy dominance by pilots, all of whom make too much money anyway. I believe that as every flight is about to depart, an appropriate Flight-Care Council should be formed. It would, of course, include the pilot, whose technical expertise is undeniably required. The council would also include among its members appropriate representatives of the ground crew and the flight crew. The majority of the members, however, should be flight-care consumers, chosen on the basis of a careful consideration of the sexual, ethnic, and religious makeup of the consumer group on the flight in question.

The Flight-Care Council would be responsible for making key policy decisions with respect to the flight, including the time of take-off, the altitude at which the aircraft would fly, where the flight would stop along the way, and the ultimate destination.

After the landing, an Airstrip Utilization Review Committee would make a determination of whether the landing was indeed necessary. In the event that it is deemed to have been unnecessary, the pilot would be forced to take off again.

I urge that our lawmakers speedily enact appropriate legislation that will bring about these long overdue changes in the flight-care system and bring an end to the pilot tyranny that has resulted in maldistribution of flight-care service, unnecessary flights, and lack of attention to the real needs of consumers.

ROBERT B. HOWARD, M.D.

* This appeared in the *Orange County Medical Association Bulletin* in Orange County, California. We thank them for allowing us to reprint it in the *Journal*. It was submitted to us by MAG member, Donald R. Rooney, M.D.

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As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from January through March 1978.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Jung Hong Ahn, La Grange
Vicente Roberto Ajoy, Jonesboro
Manuel Lazaro Alvarez, Savannah
Ramon Vicente Alvarez, St. Marys
Amarasinghe Amarasinghe, Augusta
Michael Richard Antopol, Fort Benning
William Jackson Atha, Rome
James E. Barfield, Vidalia
Charles Oliver Barker, Valdosta
Jackson Howell Bates, Marietta
Julian Berdusco, Augusta
Charles Joseph Betz, Rome
Ronald C. Bloodworth, Smyrna
William Frank Bloom, Macon
Daniel Sender Blumenthal, Atlanta
James Amos Brigman, Atlanta
Alan Paul Brown, Savannah
William Owen Brown, Moultrie
Rodney Mack Browne, Macon
Carson B. Burgstiner, Savannah
Louis G. Cacchioli, Hartwell
James Maxwell Carson, Atlanta
Albert Liu-Chian Chen, Dublin
Jay Sheldon Coffsky, Atlanta
David Max Cohen, Atlanta
Richard Schirmer Colvin, Atlanta
James Thomas Cooper, Marietta
Harry Eugene Dawson, Adairsville
Jordan Arthur Dean, Decatur
Abelardo R. Delgado, Milledgeville
Allan Jay Dinnerstein, Jonesboro
William C. Ferrell, Gainesville
Edgar Joseph Filson, Savannah
Douglas Houston Forsyth, Atlanta
Robert Arthur Gadlage, Decatur
John White Garland, Gainesville
James Riley Gettys, Fort Stewart
Stewart Dixon Gilbert, Tifton
Sara Lambeth Goolsby, Rossville
Antonio Jose Gracia, Valdosta
Vernon Jackson Grantham, Fort Valley
Mack Varnedoe Greer, Valdosta
Basil Manly Griffin, Atlanta
Dieter Karl Gunkel, Savannah
Jerold Alan Haber, Roswell
Richard L. Hanberry, Macon
Abulkalam Wahidul Haque, Atlanta
Frank Hardeman, Savannah
Donald Harrison, Savannah
Chih-Ta Ho, Americus
Jesse Lindsey Hunt, Brunswick
Dirk Erik Huttenbach, Marietta
Cecil F. Jacobs, Portal
Clyatt Wendell James, Macon
Henry S. Jennings, Gainesville
George Winford Jones, Atlanta
Phillip Henry Kaleida, Dalton
Hyun Hahk Kim, East Point
John D. King, Atlanta
Mario Octavio Laosa, Milledgeville
Paul Alan Lavietes, Atlanta
Raphael S. Levine, Chamblee
Jeffrey B. Lichtman, Atlanta
Teodulo Mendez Llorente, Rome
Edwin P. Lochridge, Atlanta
Murugiah Mani, Atlanta
Gualberto Marrero, Fort Gordon
Marcial Martinez, Valdosta
Willie Esther McAlpine, Atlanta
Allen Pierce McDonald, Decatur
Philip Robert B. McMaster, Atlanta
William Swanson Millians, Atlanta
George E. Mixon, Dublin
Snead Wesley Morgan, Dublin
Jose Behar Namer, Tucker
Jule C Neal, Macon
Ruth E. R. Neal, Augusta
John Bruce Neeld, Marietta
Francisco Jose Negri, Austell
Charles Francis Nicol, Atlanta
Rex Beach Perkins, Doraville
Peter Phillips, Atlanta
Roberto Raul Pineyro, Milledgeville
Quentin Price, Dublin
Ahmad Rahbar, Decatur
Stephen Norton Rando, Macon
Baber Zaheer Rathur, Riverdale
Larry Graydon Ray, Atlanta
Rafael G. F. Razuri, Savannah
John Dixon Reynolds, Augusta
James Van Robertson, Blairsville
Antonio R. Rodriguez, Martinez
Alexander P. Russell, Savannah
Ruth Talley Sanders, Augusta
Kenneth Anthony Scheidt, Atlanta
Romero M. Sealey, Atlanta
Zouheir A. Shama, Chamblee
Douglas Julian Sharpton, Lavonia
Syed Haider Ali Shirazi, Cairo
William C. Shirley, Macon
Ivy Lee Shuman, Sylvania
William Gains Slaughter, Augusta
James W. Smith, Manchester
Jack Lee Sorg, Atlanta
David Paul Sorkey, Columbus
Paul Eugene Stanton, Atlanta
Byron Harold Steele, Fairmount
George Yih-Liang Tseng, Albany
George Sylvanus Walker, Eastman
Stanley William Wallace, Atlanta
Luiz Weksler, Macon
Ralph Edwards Wesley, Atlanta
Desiderius C. Whidder, Atlanta
Stewart Earle Wiegand, Atlanta
Roy Allen Wildey, Savannah
Charles Edward Wills, Washington
Robert K. Worman, Columbus
Frederick E. Youngblood, Augusta

Lawrence J. Henderson *[1878-1942]: Somewhere between 1910 and 1912 in this country, a random patient, with a random disease, consulting a doctor chosen at random had, for the first time in the history of mankind, a better than fifty-fifty chance of profiting from the encounter.*

Quoted in the New England Journal of Medicine *270:449, 1964.*

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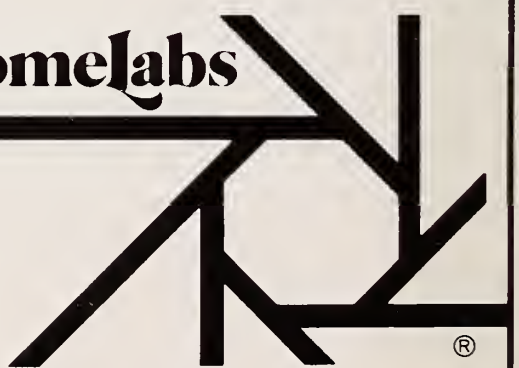
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Ecklund, Robert D., Stephens-Rabun — N1 — GP
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Fromm, Stefan H., Whitfield-Murray — ACT — GS
P.O. Box 1969, Dalton 30720

Hall, Arthur L., Troup — N2 — FP
Clark-Holder Clinic, 303 Smith St., LaGrange 30240

Hall, Pamela Pearson, Troup — N2 — FP
Clark-Holder Clinic, 303 Smith St., LaGrange 30240

Harvey, James S., Hall — N2 — FP
403 Hawkins St., Dahlonega 30533

Jenkins, Walter T., Hall — N2 — OBG
254 S. Enota Dr., NE, Gainesville 30501

Johnson, Grady Hugh, Laurens — N2 — FP
426 Academy Ave., Dublin 31021

Maramreddy, Padmamabhareddy, Laurens — S — IM
VA Center, Dublin 31021

Rao, Arepally V., Laurens — S — PM
VA Center, Dublin 31021

Rhim, Sung Y., Clayton-Fayette — N2 — AN
409 Arrowhead Blvd., Jonesboro 30236

Shah, Jyoti, Laurens — N2 — P
VA Center, Dublin 31021

Sham, Ramesh M., Laurens — S — IM
VA Center, Dublin 31021

Smith, Roger Deane, Laurens — N2 — OPH
505 Academy Ave., Dublin 31021

Thomas, Fred Burgess, Jr., Hall — N2 — PS
1224 Sherwood Park Dr., NE, Gainesville 30501

Vereen, H. Stacy, Blue Ridge — ACT — GP
Fannin Regional Hospital, Blue Ridge 30513

Westfall, David N., Hall — N2 — FP
668 Lanier Park Dr., NE, Gainesville 30501

SOCIETIES

At their November meeting, the members of the **Cobb County Medical Society** heard Harrison Rogers, M.D., MAG's AMA delegate and Vice Speaker of the AMA House of Delegates. Other business included election of new officers and approval of the 1979 budget.

The third and final forum on heart disease presented by the Cobb County Medical Society was held November 14 at Dodgen Middle School. Panel participants for the evening were: Steve May, M.D., family practice; Evans Nichols, M.D., obstetrics and gynecology; Jerome Blumenthal, M.D., cardiology; Richard Smith, M.D., cardiovascular surgery; and (Moderator) Lamar Cousins, M.D., internist. The meetings were held as a public service.

For their October meeting the members of the **DeKalb Medical Society** heard Fourth District Congressman Elliott Levitas speak on national health legislation.

On October 10, the **Hall County Medical Society** met at the Chattahoochee Country Club for their monthly meeting. Those attending discussed such issues as obtaining release of medical information, informing physicians about the cost of laboratory tests and medicines administered in hospitals, developing a public information service, appointing a committee to study the present emergency transport system, distributing information on legal aspects of physician-lawyer relationships, and advertising of physicians in the yellow pages of the telephone book.

The **Medical Association of Atlanta** Board of Trustees adopted a resolution urging its members to voluntarily hold fee increases below the general inflation rate. The action was recommended by the Association's committee on cost accountability and is in response to a challenge made by Thomas Nesbitt, M.D., President of the AMA, to help stabilize inflation.

The 5th annual **Muscogee County Medical Society** Doubles Tennis Tournament was completed on Sunday, October 29, at the Columbus Tennis Club. The tournament started in April of this year and because of the postponements caused by medical emergencies, medical meetings, etc., this tournament is probably the longest running one of its kind in the Columbus area. It has been dubbed, "The Beeper Tournament." Doubles winners were Marvyn Cohen, M.D., and Dan Sigman, M.D. Runners-up were Al Alvarez, M.D., and Stuart Levi, M.D. Semi-finalists were Frank Star, M.D., Chris Shields, M.D., Fred Burdette, M.D., and J. W. R. Davis, M.D. Dr. Shields was Tournament Chairman. The Lederle Trophy is presented annually to the Society by Mr. Dick Thompson, a representative of Lederle Laboratories.

PERSONALS

Second District

John G. Bates, M.D., has been named a Fellow of the American Academy of Family Physicians.

Chappell A. Collins, Jr., M.D., from Albany, has been elected to serve as a board member of the Georgia Heart Association (GHA). Since 1975, he has served the GHA as Chairman of the Cardiology Conference.

Charles Finney, M.D., has been elected chairman of the Board of Trustees of the Palmyra Park Hospital. Other

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new board members include **Morton Boyette, M.D.**, and **Robert Groves, M.D.**

The medical staff of Tift General Hospital has elected **Richard E. McCullough, M.D.**, to the position of Chief of Staff. Other officers for the coming year include **William D. King, M.D.**, Vice Chief of Staff, and **Larry Moorman, M.D.**, Secretary-treasurer.

The Colquitt County Hospital Authority and medical staff honored **W. R. McGinty, M.D.**, with a special "Recognition" plaque. Dr. McGinty retired from medical practice earlier this year after having served the Moultrie community for 48 years.

Charles R. Sheffield, Sr., M.D., from Dawson has recently joined the medical staff of the Americus and Sumter County Hospital. He has assumed direction of the hospital's emergency room. His addition to the staff has provided the community with almost 24-hour service 7 days a week and has enabled the hospital to expand its emergency medical services. For instance, the emergency personnel can now contact the hospital en route to the facility and receive instruction that will allow them to begin treatment of an emergency patient before arrival at the hospital.

John Pierce Tucker, M.D., who has practiced surgery and general medicine in Moultrie since 1955, has announced his retirement. Dr. Tucker becomes one of four medical doctors in the community to retire in recent years after practicing for more than 20 years.

Joseph M. Turner, M.D., from Tifton, has been voted President of the Georgia Heart Association (GHA). He and other officers were chosen at GHA's 30th Annual Meeting in Savannah. Dr. Turner is succeeding **Nanette K. Wenger, M.D.**, from Atlanta.

Fourth District

Joseph Lawton Burton, M.D., of Doraville has been unanimously nominated by the DeKalb County commission to succeed William Anderson as County Medical Examiner. Dr. Burton, a medical examiner for Atlanta, was recommended by Coroner Bryan Cavan, who oversees medical examiner operations.

Fifth District

MAG members elected to GHP positions include: **Mark E. Silverman, M.D.**, (Atlanta) — President-elect; **Nicholas E. Davies, M.D.**, (Atlanta) — Vice President; **John D. Cantwell, M.D.**, (Atlanta) — Board of Directors; and **Chappell A. Collins, Jr., M.D.**, (Atlanta) — Board of Directors.

Sixth District

A former infirmary physician at West Georgia College has opened a private practice. **Mary Ryan Miles, M.D.**, is now practicing pediatrics in Carrollton and is tentatively planning special evening office hours to treat teenagers.

Succeeding Dr. Miles at West Georgia College is **Roy L. Denney, M.D.**, who practiced medicine in Carrollton from 1946-1976. Dr. Denney has been serving as a physician with Project U.S.A., sponsored by the AMA, since his retirement. He is a specialist in ear, nose, and throat.

Seventh District

James Henry Dunfee, M.D., has opened a clinic in Dallas, Georgia, to serve both the general and special medical needs of Paulding County residents. Dr. Dunfee

hopes that the clinic will attract other physicians to the county in specialty areas not currently available locally.

George Harrison, M.D., has been elected to the presidency of the Georgia Society of Otolaryngologists.

The new officers for the Urban Medical Hospital are **Mitchell Jablow, M.D.,** Chief of Staff; **Arnold Neistadt, M.D.,** Chief of Staff-elect; **J. Thomas Cooper, M.D.,** Secretary/Treasurer.

The American College of Cardiology has announced the names of physicians and surgeons newly admitted to the Fellowship. The new Fellows from MAG are **Maury C. Newton, Jr., M.D.,** from Marietta, and **Raymond A. Young, M.D.,** from Rome.

At the recent annual meeting of the Georgia, Alabama, and Mississippi Urological Meeting **Fred Schmidt, M.D.,** was installed as the 1978-79 President of the Georgia Urological Society. **Ronald Roper, M.D.,** was elected to a 3-year term as Secretary for the Georgia Urological Society and serving the same capacity for the Tri-State Urological Assembly.

On November 4, 1978, a paper written by **Carlos A. Selmonosky, M.D., James Blanc, M.D.,** and **Randy Byrd, Pu.T.** was presented to the Southern Thoracic Surgical Association at their 25th Annual Meeting at Marco Island, Florida.

William F. Wieland, M.D., has been elected to the Board of Directors of the North Central Georgia Health Systems Agency.

Eighth District

Immediate past president of MAG, **Milton I. Johnson, Jr., M.D.,** has been installed as President of the Georgia Academy of Family Physicians at the annual president's banquet in November.

O. C. Wynn, M.D., who worked with the Ware County Board of Health for 43 years, was honored last week on his retirement from the public health job. Dr. Wynn was presented a plaque at the luncheon given in his honor by the health department. Tom Gattis, Chairman of the Ware Board of Health, presented the plaque and paid tribute to the physician for his loyal and dedicated service to the people of the area.

Ninth District

James E. Marlow, M.D., has recently been installed as President of the medical staff at Hamilton Memorial Hospital. **Paul E. Henson, Jr., M.D.,** is the new Vice President, and **William M. Blackman, Jr., M.D.,** serves as Secretary. Drs. Marlow, Henson, and Blackman will serve for 1 year in their elected positions, directing medical affairs at the hospital and serving on the medical staff's Executive Committee.

Tenth District

The Rockdale County Hospital Authority recently approved the addition of two physicians to the hospital's medical staff. **Millard I. Ross, M.D.,** was approved for active staff privileges, and **Henry La Salle, M.D.,** was approved for courtesy staff privileges.

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DEATHS

Robert P. Shinall, Jr.

Robert P. Shinall, Jr., M.D., died on August 17 at the age of 54. He had had a general practice in Decatur for 9 years and then practiced dermatology in Atlanta until 1968, when he was forced to retire after a heart attack.

Dr. Shinall graduated from Emory University, Emory University Medical School, and New York University. He served with the Army Medical Corps in World War II.

He was a member of the Medical Association of Atlanta, the American Medical Association, the American Academy of Dermatology, and the American Academy of Family Practice, and the Georgia Arthritis Foundation. In 1969, he received the Aven Cup given by the Medical Association of Atlanta to an outstanding physician in the area.

He was a past president of the Kiwanis Club of Decatur, former member of the board of directors of the DeKalb Chamber of Commerce, and was chosen "Young Man of the Year" by the Decatur Lions in 1957.

He served as fourth district chairman of the Republican Party; he also was active in the Druid Hills High School PTA and served for many years as physician for athletic teams at the school.

Survivors include his wife, two sons, a daughter, a sister, and his mother.

William A. Hendry, Sr.

William A. "Bill" Hendry, Sr., 67, died on September 16 at his home following a long illness.

A native and life-long resident of Blackshear, he was a graduate of the University of Georgia Medical School, Class of 1938. He practiced in Blackshear until his retirement in 1974 because of bad health. He served as Chief of Staff of the Pierce County Hospital and was a member of the American Medical Association, the Medical Association of Georgia, and the Ware County Medical Society. He served as Medical Examiner for Pierce County for a number of years, and during World War II, he was Battalion Surgeon for the 101st Sep. C.A. BN(AA) at Fort Stewart.

He was one of the founders of the Peoples Bank, was a member of the First United Methodist Church, and a member of the Still Lake Fishing Club.

Survivors are his wife, a daughter, four sons, a brother, two grandchildren, and several other relatives.

Burch Joiner Roberts

Burch Joiner Roberts, M.D., 74, a Cornelia physician for many years, died on September 15 following an extended illness. A native of Dawson, he began medical practice in Cornelia in 1935 and served the people of the community until 1961, except for a period of service in the U.S. Army during World War II.

In 1961, he went with the public health department of the state, and in 1962, was hired as District Health Director for a five-county area, with headquarters in Griffin. In 1966, he returned to north Georgia to help establish a district health department for six counties.

He was a member of the Cornelia United Methodist Church, Masonic Lodge No. 92, F & AM, and the Cornelia Kiwanis Club.

Dr. Roberts served as Mayor of Cornelia in the 1950's, was one of the founders of the Cornelia Chamber of Commerce, and was a member of the Georgia Public Health Association until his death.

Survivors include his wife, one daughter, and four grandchildren.

Richard W. Moore

Richard W. Moore, M.D., Savannah, died on October 1 at the age of 71, following a long bout with cancer.

Born in Darien, Georgia, he received his elementary and high school training at Haynes Institute in Augusta and his B.A. at Lincoln University. He received his M.D. at Howard University and completed his internship and residency at Homer G. Phillips Hospital in St. Louis.

He was appointed city physician for Savannah in 1935 and served as such for 35 years.

He was a member of the Medical Association of Georgia (MAG) and was awarded its gold life membership card in 1977. As a member of the MAG he served more than 30 years as its treasurer. He was president emeritus at the time of his death.

He was a member of the staff of Candler General, St. Joseph's, and Memorial Medical Center, and was past Medical Director of the now defunct Charity Hospital and William A. Harris Memorial Convalescent Center.

He was Medical Director of the Savannah Plasma Center, past President and Treasurer of the South Atlantic Medical Society. Other positions held by Dr. Moore include Chairman of the Board of Carver State Bank and Director of the Toomer Realty Corporation. He served as president of the Savannah Chapter of National Guardsmen from 1974 until 1976. He was a member of St. John Baptist Church and had served on its Board of Trustees.

Surviving him are his wife, a son, six daughters, a brother, two sisters, and three grandchildren.

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Richard Blanton Wilson

Richard Blanton Wilson, M.D., Atlanta, died October 2 after a long illness.

Dr. Wilson began his practice of neurology in 1930 and retired in 1970. He was recently named professor emeritus at Emory University and was an honorary staff member at Emory University Hospital.

Dr. Wilson graduated in 1922 from the Emory University School of Medicine. He did graduate work at the Boston Psychopathic Hospital and the Peter Bent Brigham Hospital, followed by studies at the Brain Institute, Amsterdam; Frieddrichsburg-Angestadt, Hamburg; the University of Vienna; National Hospital, London; Foxboro State Hospital in Massachusetts; and Bellevue Hospital in New York City.

Dr. Wilson was a member of the American Medical Association, The American Academy of Neurology, the Medical Association of Georgia, and the Atlanta Medical Association. He taught neurology at Emory for more than 40 years and was former president of Emory University's Atlanta Alumni Association.

Dr. Wilson was a Navy veteran of World War II and a retired captain of the U.S. Naval Reserve. He was a member of Sigma Alpha Epsilon, Alpha Kappa Kappa, and Phi Beta Kappa fraternities.

Charles Henry Dickens

Charles Henry Dickens, M.D., from Morgan County, died on October 5 at the age of 88; he had suffered a stroke several weeks prior to his death.

Born in Gwinnett County, he attended school in Norcross and in 1913, received his M.D. degree from the Georgia College of Medicine and Surgery.

At the onset of World War I he was commissioned a First Lieutenant in the Medical Corps and remained in the service until 1919.

He served as Chairman of the Morgan County Board of Health, and during his years of practice in the county, delivered more than 3,500 babies, often in isolated areas under adverse circumstances. He served as Chief of Staff at Morgan Memorial Hospital. He was a Fellow of the American Academy of Pediatrics and of the Academy of General Practice, a member of the Tenth District, Georgia State and Southern and American Medical Associations, and served for 2 years as President of Oconee Valley Medical Society. He was also a member of Madison Methodist Church, the American Legion, Madison Kiwanis Club, Morgan County Foundation, and Morgan County Historical Society.

Dr. Dickens is survived by his wife, two children, three grandchildren, a great-granddaughter, two nieces, and two nephews.

Several years ago, Dr. Dickens wrote, "As a physician one must not only attend people physically but must also be prepared to listen when patients tell of their problems of life. . . . My work has not been easy. There is no such thing as a 40-hour week with 2 weeks paid vacation. One is on call for 24 hours, with 16 to 18 hours daily, for 365 days per year and a vacation if and when one can find the time."

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MAGNET '78

FOR THE 7TH CONSECUTIVE YEAR, the Public Relations Committee of the Medical Association of Georgia (MAG) organized and sponsored a MAG New Educational Training (MAGNET) Conference that was held on October 21-22, 1978, at the Terrace Garden Inn in Atlanta.

According to Marvyn D. Cohen, M.D., chairman of the Public Relations Committee, MAGNET '78 was "one of the best meetings for the money that MAG offers."

In keeping with the format of presenting practice management techniques to improve the efficiency of physicians' office operations, this conference focused on "Fighting Inflation — While Maintaining Quality Care."

This year's program also included a half-day session on "What to Do Before and After the Doctor Dies." Auxiliary members, along with their husbands, were informed in such matters as probate, wills, trusts, choosing an executor, and other topics of estate planning.

A total of 133 physicians, their spouses, and physicians' personnel attended the 2-day meeting. Judging by the increased enrollment (up 28% from last year), and the evaluations completed by the attendees, MAGNET '78 was a success!

Dr. Cohen adds that because of the tremendous response to the session on estate planning, a similar program is being planned for the major cities around the state.



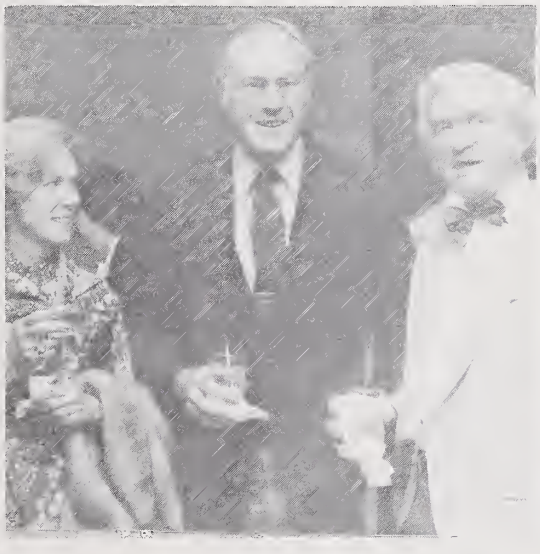




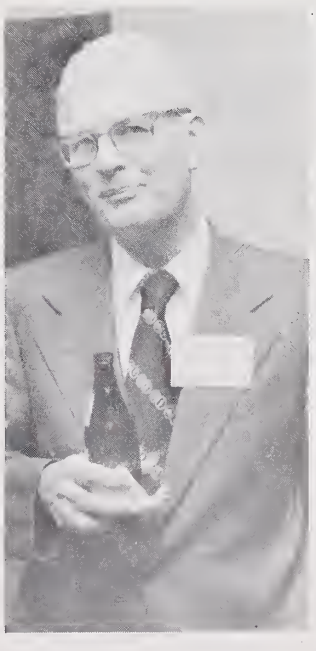
ABOVE LEFT: Greg Gates discusses some of the problems associated with the high cost of living. MIDDLE: Drs. Carson Burgstiner, Earnest Atkins, and Milton Johnson learn about the effects of inflation on office management. BELOW: Improving practice management techniques is one way to curb the effects of inflation. Here, conference attendees learn how. OPPOSITE, LEFT TOP: John Kiser takes a break during the morning session. Cooperation among our leaders is a must. Here, Jim Moffett and Carson Burgstiner share some conversation with each other as well as a smile for the photographer. Dr. Earnest Atkins (far right) is equally cooperative. MIDDLE LEFT: Dr. E. M. Molnar from Columbus visits with a colleague during the morning break. Dr. and Mrs. L. Newton Turk III and Dr. Bruce Newsom enjoy themselves at the Saturday night cocktail party. RIGHT MIDDLE: Dr. Marvyn Cohen advises Ken Williams on how to plan a successful conference. (Why is Ken laughing?) LEFT BOTTOM: Mrs. Ann Moffett and Mrs. Jacque Burgstiner enjoy a rest at the Saturday night party. Dr. Milton Johnson and his wife, Joyce, also have some fun at the party. (Who says getting your picture taken has to be dull?)















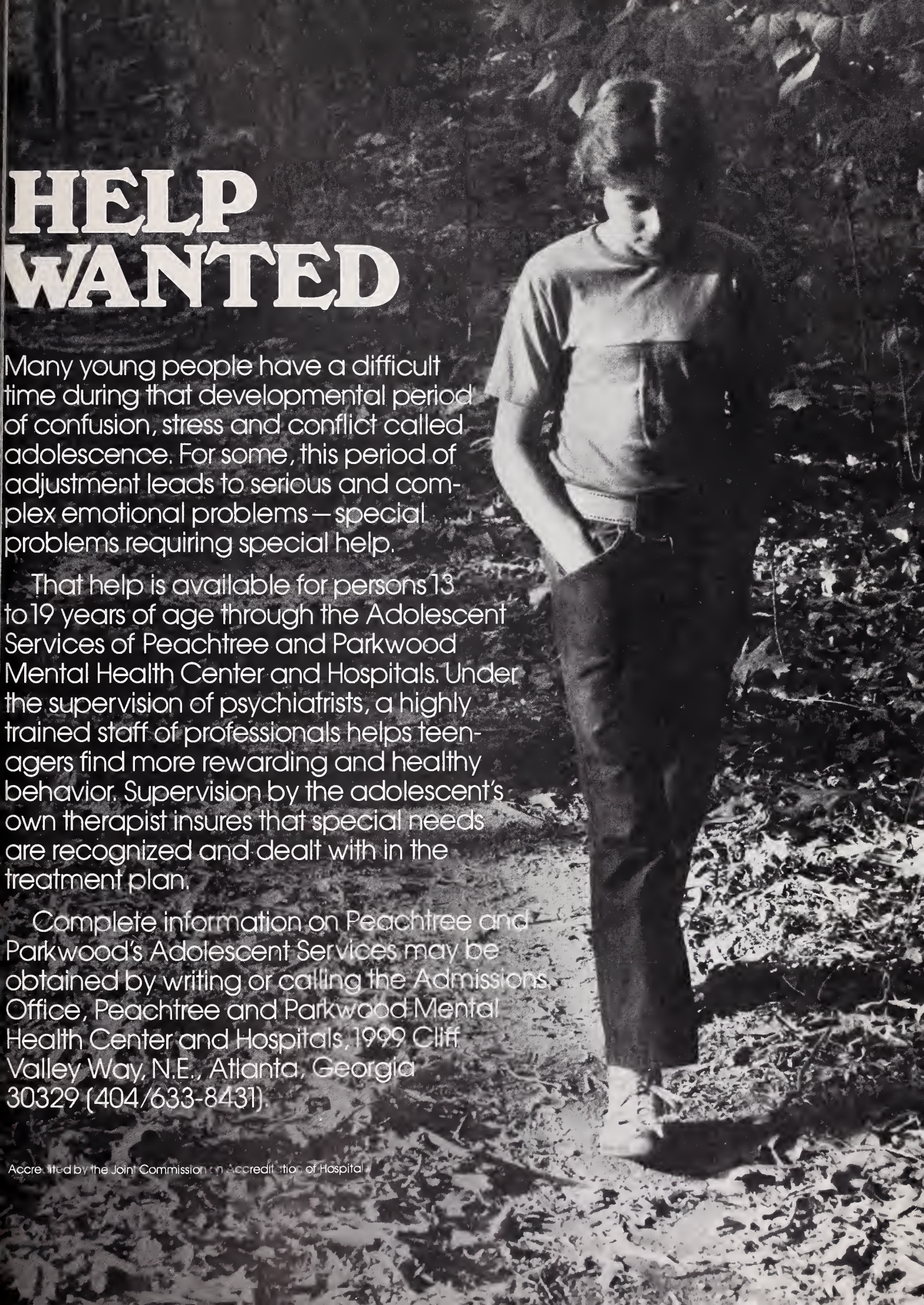





TOP RIGHT: MAG often finds itself in the middle of issues and answers regarding health care delivery. Accordingly, MAG staff member Tom Sawyer finds himself in the middle of a lively discussion at the Saturday night cocktail party. The MIDDLE photographs depict a sample of the many attractive people who contributed to the good times enjoyed by all at the Saturday night party. The couple pictured in the BOTTOM RIGHT are newlyweds from Gainesville. BOTTOM LEFT: Dedicated people are key to any successful endeavor. Such were MAG staff members Lola Brown and Emily Bisplinghoff who handled many of the countless arrangements that helped to insure the success of Magnet '78.







HELP WANTED

Many young people have a difficult time during that developmental period of confusion, stress and conflict called adolescence. For some, this period of adjustment leads to serious and complex emotional problems—special problems requiring special help.

That help is available for persons 13 to 19 years of age through the Adolescent Services of Peachtree and Parkwood Mental Health Center and Hospitals. Under the supervision of psychiatrists, a highly trained staff of professionals helps teenagers find more rewarding and healthy behavior. Supervision by the adolescent's own therapist insures that special needs are recognized and dealt with in the treatment plan.

Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

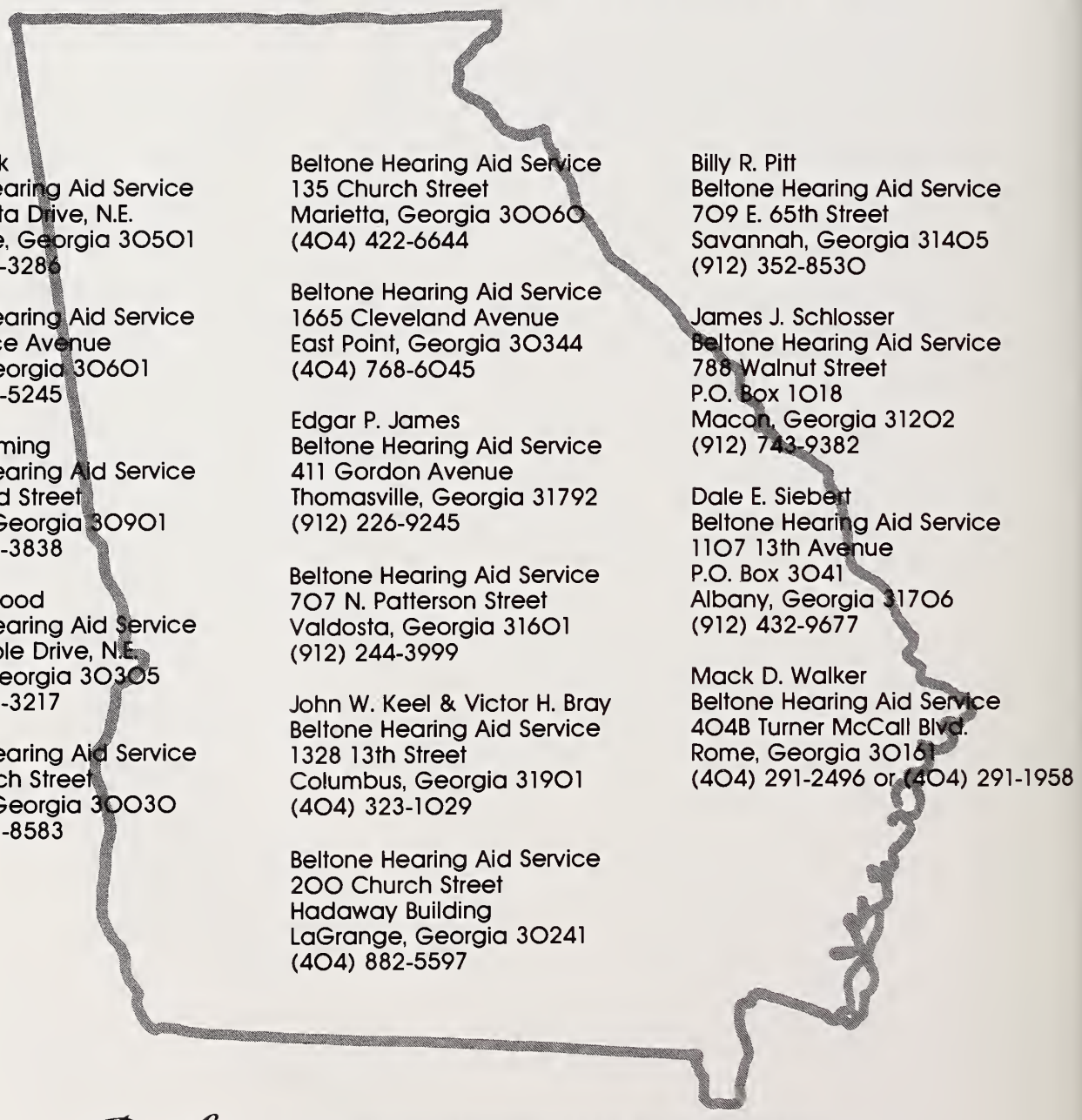
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I've told this before . . .

(Editor's note: Sometimes our blessings are initially well-disguised to the contrary. See how in this heart-warming story by Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories to the Journal, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

An Accidental Christmas Present

It was a beautiful Christmas Eve afternoon. Maria and Andrew had been to a Christmas party at the church. They had sung carols, listened to stories, and had their fill of punch and cakes. They had been going steady for about 2 months and were quite popular in high school. Maria was 15, pretty, blondish, and had a trim, neat figure. Andrew was 16, a clean-cut youngster, and had just recently gotten his driver's license.

On the way home, just at sundown, they were moving along nicely with the flow of fairly heavy traffic. Suddenly, a confused dog crossed the road in front of their car. Andrew hit his brakes and swerved to miss the dog. In so doing, he ran off the road and head-on into a sturdy pine tree. Maria was thrown forward, and her nose struck a knob on the dashboard with such force that it was flattened almost even with her face. As is common with such injuries, there was a great effusion of blood. Her dress, her hose, and even her shoes were soon soaked.

By the time they arrived at the emergency room of the hospital, the bleeding was under control. A cursory examination by the emergency room doctor revealed that the only damage was to her nose. She lay on the hospital cart while heart-broken Andrew called her parents.

When Maria's mother arrived, she almost fainted when she saw her daughter lying on the hospital stretcher, her lovely party dress, hose, and shoes stained with dried blood. She was comforted, however, when the nurse assured her that the only problem was a smashed nose and that there was an eminent plastic surgeon on hand, just finishing an operation in the next room. He had been notified about Maria's injury and said he would be glad to handle the case. He said he would like to have some recent pictures of Maria, especially of her profile, so he could mold her nose back like it was.

"Well, I pray that he can," replied the mother, "because she had such a beautiful nose."

The pictures were obtained and after a 1-hour operation, the surgeon told her parents that she was doing fine and would be awake soon. He said that he would like for both of them to be present when he saw Maria the following morning at 11:00 a.m.

The next day was Christmas. The surgeon came by Maria's room and found her sitting up in bed. Her face was swollen, and the tissue around her eyes was puffed up and blue. She had eaten a good breakfast and seemed happy to be alive. Her parents were there, and despite their anxiety, they too seemed happy and pleased. Only the doctor seemed a little disturbed.

He sat down and said, "I hate to tell you this, but I have not been able to mold Maria's nose back the way it was. In the pictures she had a little arch in it, but it was crushed so badly that I could not get the arch back. Her nose will now be more or less straight.

The ensuing silence was soon broken by Maria's sobbing. The tears streamed down her swollen face and onto her flimsy gown. So great was the flow that her gown was soon soaked in no time. Tears welled up in her mother's eyes.

This upset the kindly doctor, and he went over and put his arm around Maria and said, "Now, Maria, if you will accept this straight nose for about 6 months, I will bring you back here then, take out a small piece of your rib and put the arch back in your nose. And you won't have to pay me a thing."

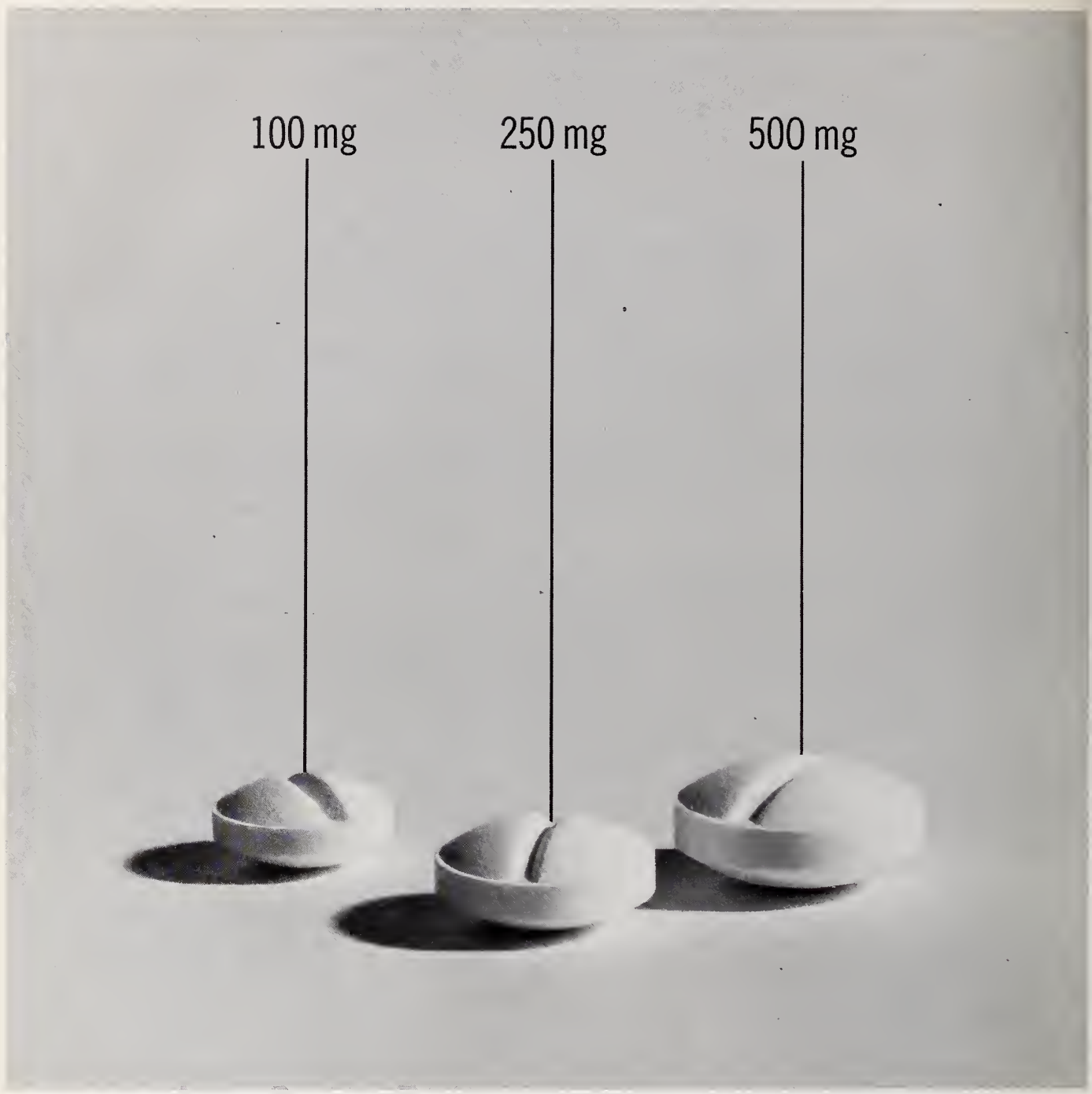
"Oh! No! No! No!" sobbed Maria as she looked up into the sympathetic eyes of the doctor. "My crying is from happiness! For years I have wanted a straight nose. My mother always said that it was a distinguished nose from her side of the family, but I hated it. My little brothers used to tease me and sing,

'Hump back nose, turned down toes,
Here she comes, there she goes.'

And several of my girl friends have told me confidentially that I would be pretty if it were not for my nose. Oh! I'm *so* happy! What a wonderful Christmas present!"

And the tears commenced all over again!

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MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.



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Oliver Wendell Holmes *[1809-1894]: Once in a while you will have a patient of sense, born with the gift of observation, from whom you may learn something.*

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JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

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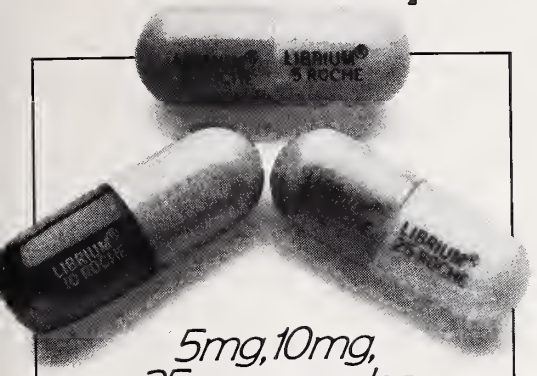
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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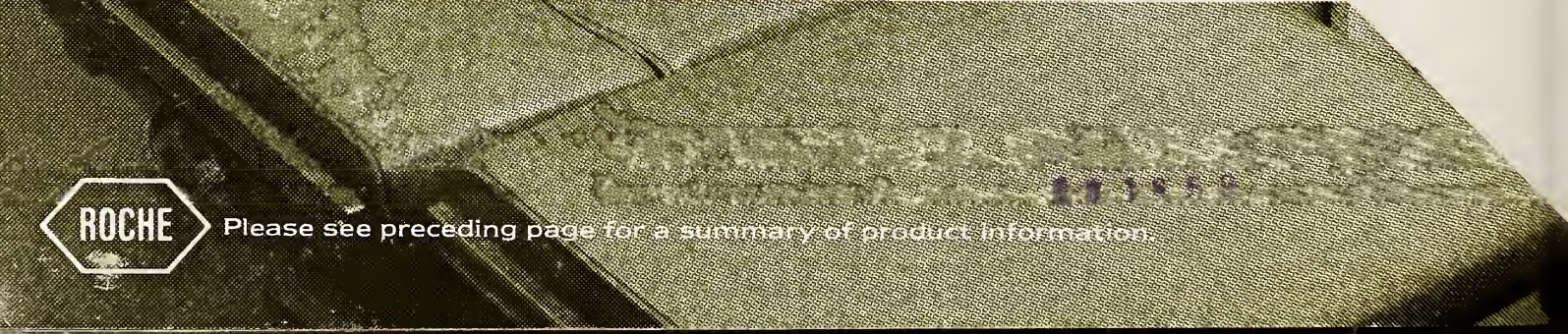
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